

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY

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AGS26

VIRTUAL

AGS Geriatrics
Healthcare
Professionals
Leading Change. Improving Care for Older Adults.

AGS 2026 VIRTUAL ANNUAL SCIENTIFIC MEETING

MEETING DATES: Thursday, April 30—Saturday, May 2 **PRE-CONFERENCE DAYS:** Monday, April 27—Wednesday, April 29

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American Geriatrics Society 2026
Annual Scientific Meeting

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JOURNAL OF THE AMERICAN GERIATRICS SOCIETY

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ABOUT THE AMERICAN GERIATRICS SOCIETY

WHO WE ARE: Founded in 1942, the American Geriatrics Society (AGS) is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our members include thousands of geriatricians, advanced practice nurses, social workers, family practitioners, physician assistants, pharmacists, and internists who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons.

The Society provides leadership to healthcare professionals, policymakers, and the public by implementing and advocating for programs in clinical care, research, professional and public education, and public policy that can support us all as we age.

OUR MISSION: To improve the health, independence, and quality of life of all older people.

OUR VISION FOR THE FUTURE: We are all able to contribute to our communities and maintain our health, safety, and independence as we age.

We all have access to high-quality, person-centered care informed by geriatrics principles and free of ageism.

We all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers.

STRATEGIES FOR ACHIEVING OUR VISION

1. Expanding the geriatrics knowledge base by disseminating basic, clinical, and health services research focused on the health of all older people.
2. Increasing the number of healthcare professionals employing geriatrics principles when caring for diverse older persons by supporting the integration of geriatrics concepts into health professional education.

3. Recruiting diverse healthcare professional trainees into geriatrics by focusing on the rewards and potential of a career caring for older people.
4. Advocating for public policy that promotes the health and independence of diverse older Americans, with the goal of improving health, quality of life, and healthcare systems serving us all as we age.
5. Creating awareness about the ways geriatrics can support diverse older people remaining active, independent, and engaged in our communities.
6. Working across our other strategic priorities in health care to identify and eliminate ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of social and structural bias/discrimination given their impact on health, safety, and independence as we age.

LEARN MORE: Visit www.americangeriatrics.org to learn more about the Society and its programs.

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SOCIETY: Correspondence relating to membership should be addressed to the American Geriatrics Society, 40 Fulton Street, 18th Floor, New York, NY 10038. Membership is open to all physicians and others interested in the health care of the older adult and fields of research directed toward its advancement. For more information on the American Geriatrics Society or to become a member, visit www.americangeriatrics.org.

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Dear Annual Meeting Attendee:

The American Geriatrics Society Annual Scientific Meeting is the premier educational event in geriatrics, providing the latest information on clinical geriatrics, research on aging, and innovative models of care delivery. The 2026 Virtual Annual Meeting will address the professional and educational needs of geriatrics professionals from all disciplines through state-of-the-art educational sessions and research presentations.

This supplement of the *Journal of the American Geriatrics Society* is devoted to abstracts of the scientific presentations that are scheduled for the 2026 AGS Annual Scientific Meeting. We are hopeful that this supplement will be helpful to those of you who are planning to attend the meeting so as to maximize your attendance at educational, research, and clinical presentations of interest to you.

We are also pleased to provide these abstracts to subscribers of the Journal. We believe that they are an important way of keeping JAGS readers up-to-date on the latest advances in the field.

Sincerely,

Nicole J. Brandt, PharmD, MBA, BCGP, BCPP, FASCP
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Paul Mulhausen, MD
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AMERICAN GERIATRICS SOCIETY 2026 ANNUAL SCIENTIFIC MEETING

April 29 - May 2, 2026

Pre-Conference Sessions: April 27 - 29

RESEARCH PRESENTATIONS
SCHEDULE AT A GLANCE

WEDNESDAY, APRIL 29, 2026

7:00 PM – 8:00 PM EASTERN
POSTER SESSION A

THURSDAY, APRIL 30, 2026

10:00 AM – 11:00 AM EASTERN
EPIDEMIOLOGY PAPER SESSION

Impact of Discrepant Kidney Function Estimates on Medication Dosing in Older Adults

Matthew E. Growdon, MD, MPH

Wildfire Smoke as a Trigger for Acute Angle-Closure Glaucoma

Aparna Reddy, BA

Purpose and Happiness Shape Older Adults' Preferences for Length of Life vs Quality of Life: Findings From a National Study

Niousha Moini, MD, MPH

Medication Regimen Complexity and Caregiver Difficulty in Assisting with Medication Management in U.S. Older Adults

Maryanne Kim, PharmD, MS, PhD

11:15 AM – 12:00 PM EASTERN
PLENARY PAPER SESSION

Sacubitril/Valsartan Use Across Transitions between Community, Hospital, and Skilled Nursing Facility Settings

Andrew R. Zullo, PharmD, PhD

Effectiveness of Pharmacist-Led Telemedicine Deprescribing Vs. Usual Care for Older Adults with Cognitive Impairment: A Pragmatic Randomized Clinical Trial

Ariel R. Green, MD, PhD, MPH

Measuring Hospitalization, Deaths, and Hospice Care from Skilled Nursing Facility Electronic Health Records vs. Medicare Claims

Christopher M. Santostefano, MPH, RN

1:15 – 2:15 PM EASTERN
GERIATRIC EDUCATION PAPER SESSION

Exploring Users' Perspectives of the Driving and Dementia Roadmap

Gary Naglie, MD, FRCPC, FCGS, FGSA

Feasibility and Efficacy of Advance Care Planning Pop-Ups Among Urban, Community-Dwelling Older Adults

Karina A. Mak, BA

A Virtual Geriatric Case Competition Offers a Scalable Activity for Health Science Students to Achieve Interprofessional Collaboration Competencies

Kristine Talley, PhD, CNP, RN, FGSA

Evidence-based Approaches for People Living with Dementia: An Educational Strategy for Healthcare Professionals
Kimberly D. Davis, PhD, RN, CNE

3:45 – 4:45 PM EASTERN

EQUITY, ACCESS, AND AGING: MEETING OLDER ADULTS WHERE THEY ARE PAPER SESSION

Anticipatory Grief Experiences of Rural Caregivers of Persons Living with Dementia: A Qualitative Analysis
Nathan Chu, BS

Racial & Ethnic Differences in Analgesic Prescribing for Older Adults with Cancer Before and After 2016 CDC Guideline
Lizzy Rueppel

Association of Gut Microbiome with Hypertension in Puerto Ricans
Alexandra M. Rivera Castro, MD

Financial Hardship and Quality of Life: Dementia Care Costs in LGBTQ+ and Non-LGBTQ+ Populations
Sara G. Jackson, PhD, LCSW

5:00 - 6:00 PM EASTERN

PRESIDENTIAL POSTER SESSION B

FRIDAY, MAY 1, 2026

10:00 AM – 11:00 AM

BETTER TOGETHER: TEAM SOLUTIONS FOR BETTER GERIATRIC CARE PAPER SESSION

Annual Wellness Visit Compliance Rate in an Academic Geriatrics Practice: A Quality Improvement Initiative
Shahrazad Tehranian, MD

Measuring Functional Status Among Older Veterans in Primary Care: Implementation Outcomes of a Hybrid Type II Trial
Rebecca T. Brown, MD, MPH

Melodies for the Mind: Implementing a Nurse-Driven Personalized Music Playlist Intervention for Hospitalized Older Adults
Jody Sharninghausen, MD & Kathleen M. Faherty, MSN, RN-BC

Nursing Staff's Response to Incorporating a Multi-Modal Sleep Hygiene Bundle to Reduce Incident Delirium in Older Adults
Kathryn S. Agarwal, MD

12:15 PM – 1:15 PM

NEW TOOLS FOR OLD PROBLEMS: ADVANCING FUNCTIONAL ASSESSMENT IN AGING PAPER SESSION

Exercise Interventions to Improve the Sixth Vital Sign (Gait Speed) in Older Adults: A Systematic Review and Meta-Analysis
Elizabeth D. Zhou, BHSc

Development of Novel Patient-Reported Outcome Measures for Older Adults Following Hospital Discharge
Claire Morton, MD

Relationship Between Pre Critical Illness Handgrip Strength and Post Critical Illness Disability
Joshua I. Gordon, MD

Development and Validation of a Severity-Stratified Predictive Model for Undiagnosed Alzheimer's Disease and Related Dementias in the Emergency Department
Natalia Festa, MD, MHS

2:45 PM – 3:45 PM
CLIN-STAR PAPER SESSION

Impact of a Geriatric Perioperative Assessment Program in Older Adults

Arpita B. Shah, MD, MPH

High-Risk Medication Prescribing Among Older Adults in the Emergency Department: A National Assessment

Sarah Follman, MD

Implementation of an Automated EHR-Based Advanced Care Planning Intervention in Primary Care

Sarah Nouri, MD, MPH

Trends in Clinical Complexity and Outcomes of Older Adults Undergoing Inpatient General Surgery

Caroline Yoon

2:45 PM – 3:45 PM
POSTER SESSION C (Students & Residents)

SATURDAY, MAY 2, 2026

10:00 AM – 11:00 AM
BRAIN HEALTH IN CONTEXT: BIOLOGY, DIAGNOSIS, AND CARE DELIVERY PAPER SESSION

Whose Job Is It Anyway? Adding a Dementia Diagnosis in the Electronic Medical Record

Karla M. Garcia Ortiz, MD

Building Cognitive Reserve in Older Adults with Hearing Loss - COCHLEA Study 72-Month Outcomes

Julia Z. Sarant, PhD, Dip Aud, BSc

Age-Friendly Health Systems Recognition and Days Spent at Home Among Hospitalized Older Adults with Dementia

Hiroshi Gotanda, MD, PhD

Blood Markers of the Renin-Angiotensin System and Brain Volumes in a Longitudinal Study

Yeonjae Lee, BS

1:00 PM – 2:00 PM
WHO BENEFITS, WHO BREAKS? MEASURING SURGICAL OUTCOMES IN OLDER ADULTS PAPER SESSION

I CAN DO Surgical Advance Care Planning: Validation of Patient Nudges for a Multi-Site Randomized Controlled Trial

Samuel E. O'Brien, MS

The Impact of Obesity Severity on Short-Term Outcomes after Geriatric Hip Fracture Surgery: A NSQIP Database Analysis

Abdulganeey Olawin, BS

Association Between Frailty and Complications in Medicare Beneficiaries Receiving Cataract Surgery

Meiyi Yu

Influence of Palliative Care Physician Participation in High-Risk Surgery Board on Goals-of-Care Discussions

Yuka Shichijo, MD

2:15 PM – 3:15 PM
HEALTH SERVICES & POLICY RESEARCH PAPER SESSION

Using a Standardized EHR Note to Identify Characteristics of Patients Reported for Elder Abuse and Self-Neglect in a National Health System

Lena K. Makaroun, MD, MS

Real-World Use of Lecanemab Among US Adults with Alzheimer's Disease

Ravi Gupta, MD, MSHP

Practice Patterns among Primary Care Clinicians Caring for People Living with Dementia: Evidence from the National Dementia Workforce Study

Jilin Tian, MS

Health Care Contact Days among Older Adults After Emergency Department Visits: A Cross-Sectional Analysis

Cameron J. Gettel, MD, MHS

Paper Session EPIDEMIOLOGY

Thursday, April 30
10:00 am – 11:00 am

P1

Impact of discrepant kidney function estimates on medication dosing in older adults

Y. Kwong, C. Chu, K. Patel, B. Michaels, C. Sun, R. Leon, W. J. Boscardin, M. Kim, R. Thomas, M. Steinman, M. E. Growdon. UCSF, San Francisco, CA.

BACKGROUND: Guidelines increasingly advocate for individualized assessment of kidney function using equations that integrate serum creatinine (Cr) and/or cystatin C (CysC), with and without indexing for body surface area (BSA). Limited data exist regarding how discrepant methods of kidney function estimation impact kidney function estimates and drug dosing/avoidance recommendations for older adults.

METHODS: Using electronic health record data from a large academic center, we identified adults ≥ 65 years with concurrent (≤ 3 months apart) Cr and CysC outpatient measurements between 1/2021 and 6/2024. We calculated the estimated glomerular filtration rate (eGFR) using the CKD-EPI Cr and CysC-based equations with and without BSA indexing. We quantified the proportion of discordant drug dosing categories based on eGFR (≥ 60 , 30–59, 15–29 or <15 mL/min or mL/min/1.73m²) and examined how drug dosing varied in two exemplar drugs (gabapentinoids and metformin).

RESULTS: Among 1485 older adults with concurrent SCr and CysC evaluation (mean age 78, 51% female, 33% Asian, 11% Black, median Elixhauser score of 5), application of the eGFR_{Cr}-CysC, eGFR_{Cr}_{BSA}, and eGFR_{Cr}-CysC_{BSA} equations led to discordant drug dosing categories in 38%, 27%, and 42% of the population compared to eGFR_{Cr} (Table 1). When integrating CysC, the kidney function estimate was often lower, indicating that dosing would need to be decreased or the drug avoided to prevent toxicity.

Overall, 9.6% (n=142) were on gabapentinoids. Based on eGFR_{Cr}, 12.7% (n=18) had higher than maximum recommended dose. This rose to 17.6% (n=25) if we applied eGFR_{Cr}-CysC instead. Among the 174 (11.7%) patients on metformin, 10.9% (n=19) had eGFR_{Cr} <30 mL/min/1.73m². This proportion would rise to 21.3% (n=37) if eGFR_{Cr}-CysC was applied.

CONCLUSIONS: Kidney function categories can change in up to 40% of older adults depending on the applied kidney function estimate, with potentially significant implications for drug dosing and avoidance recommendations. Further research is required to determine how incorporation of advanced kidney function estimates (e.g., those including CysC) affect medication underdosing and toxicity.

Comparator	Comparator eGFR concordant with eGFR _{Cr} N (%)	Comparator eGFR higher than eGFR _{Cr} N (%)	Comparator eGFR lower than eGFR _{Cr} N (%)	Total discordance N (%)
eGFR _{Cr} -CysC (mL/min/1.73m ²)	918 (62%)	54 (4%)	513 (35%)	567 (38%)
eGFR _{Cr} (BSA) (mL/min)	1046 (73%)	251 (17%)	145 (10%)	396 (28%)
eGFR _{Cr} -CysC _{BSA} (mL/min)	833 (58%)	145 (10%)	464 (32%)	609 (42%)

P2 Student Presentation

Wildfire Smoke as a Trigger for Acute Angle-Closure Glaucoma

A. K. Reddy, Z. Wakefield, X. Xiao, S. Wang. Byers Eye Institute, Stanford University, Stanford, CA.

Background: Acute angle-closure glaucoma (AACG) is an ophthalmic emergency. Fine particulate matter (PM2.5) may contribute to the risk of AACG (1). Wildfire smoke, an increasing contributor to PM2.5, has not been well studied in relation to ocular health.

Methods: We conducted a self-controlled case series using 2007–2010 MarketScan insurance claims and a wildfire-specific PM2.5 data (2,3). Adults exposed to the 99th percentile of PM2.5 smoke (≥ 22.75 $\mu\text{g}/\text{m}^3$) and with incident AACG diagnosis were included. Exposure was defined as county-level PM2.5 ≥ 1.79 $\mu\text{g}/\text{m}^3$ (50th percentile), with additional thresholds at 5.35, 10.1, 14, and 22.75 $\mu\text{g}/\text{m}^3$ (75th–99th percentiles). The incidence of diagnosis within exposure windows of 3, 7, and 30 days post-wildfire onset were compared to baseline using conditional Poisson regression.

Results: Among 12,518 AACG patients, 682 experienced an event during wildfire exposure periods. At the 99th percentile, AACG risk increased by 54% during the 3-day period after wildfire onset (IRR 1.54, 95% CI 1.31–1.82). Shorter exposure windows had stronger associations, suggesting wildfire smoke acts as an acute trigger to AACG (Figure 1).

Conclusions: This study provides the first evidence linking wildfire exposure with AACG episodes. PM2.5 exceeding ~ 10 – 14 $\mu\text{g}/\text{m}^3$ substantially elevated risk. As climate change increases wildfire activity, targeted strategies for at-risk populations is essential.

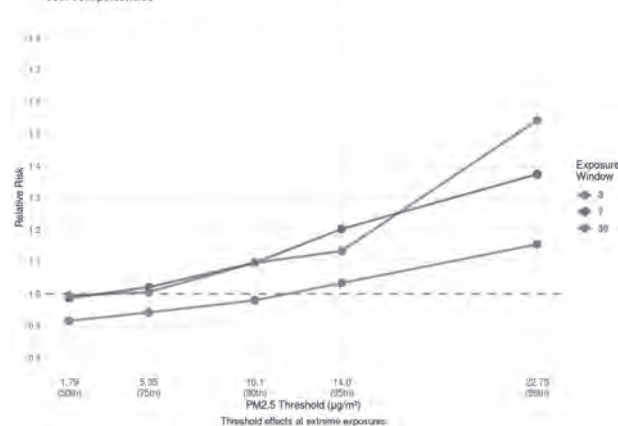
1. Li L, et al. *BMC Public Health*. 2022.

2. Burke M, et al. *Nature*. 2023.

3. Stanford Center for Population Health Sciences. MarketScan Data. 2025.

Dose-Response: PM2.5 Thresholds vs Glaucoma Risk

50th–99th percentiles



Dose-response curves represents exposure windows, demonstrating threshold effect, with extreme exposures having the strongest effects.

P3

Purpose and Happiness Shape Older Adults' Preferences for Length of Life Vs Quality of Life: Findings From a National Study

N. Moyni,² K. Wroblewski,¹ L. Waite,¹ A. K. Smith,² A. Kotwal.²
1. U of Chicago, Chicago, IL; 2. UCSF, SF, CA.

Background: Understanding how older adults value living longer versus living with major losses in independence, cognition, or social connection—core components of quality of life—is central to guiding treatment decisions and ensuring care aligns with what matters most. Little is known about whether these preferences reflect stable values or vary with psychological states such as purpose or happiness.

Methods: We analyzed the 2024 National Social Life Health and Aging Project, a nationally-representative cohort of 1,411 adults aged 60+, including a purposive sample of participants at high-risk of death. Participants were asked if they agree or disagree with the following three statements reflecting a preference for quality of life over quantity of life: “I would rather live a shorter life than lose...” 1) “the ability to care for myself,” 2) “cognitive abilities,” or 3) the “ability to do things

with family/friends.” Primary predictors included purpose in life (“my life has purpose”) and self-reported happiness. Logistic regression estimated adjusted probabilities.

Results: Participants were on average 68 years (SD 9), 56% female, 22% Black, 14% Hispanic, and 38% met prognostic criteria for high-risk of death. Overall, more participants agreed with a preference for a shorter life rather than lose independence (Agree:45%; Disagree:30%; Neutral:25%), cognitive abilities (Agree:58%; Disagree:22%; Neutral:20%), or the ability to engage socially (Agree:44%; Disagree:31%; Neutral:25%). Older adults with a higher sense of purpose were less likely to agree with a preference to live a shorter life rather than lose their independence (High purpose:48% vs Low purpose:58%, $p=0.02$) or their ability to engage socially (45%vs53%, $p=0.01$). Similarly, those reporting greater happiness were less likely to agree with a preference to live a shorter life rather than lose their independence (Happy:48% vs Unhappy:63%, $p=0.001$) or cognitive abilities (62%vs73%, $p=0.005$).

Conclusions: Purpose and happiness, potentially modifiable traits, strongly shaped how older adults weighed quantity versus quality of life. These findings suggest such preferences may partly reflect current psychological states rather than fixed values. Clinicians should revisit these conversations over time and consider how psychological well-being may influence decision making.

P4 Encore Presentation

Medication regimen complexity and caregiver difficulty in assisting with medication management in U.S. older adults

M. Kim, M. Steinman, B. Jin, B. Michaels, M. E. Growdon.
Geriatrics, UCSF, SF, CA.

Background: Medication regimen complexity can increase strain on caregivers who assist with medications. Regimens involving multiple dosage forms and dosing frequencies may represent targets for deprescribing efforts to reduce treatment burden. This study examined the association between medication regimen complexity and caregiver-reported difficulty in medication management.

Methods: We analyzed data from the 2021 U.S. National Study of Caregiving linked with the National Health and Aging Trends Study and Medicare claims. The sample included primary caregivers assisting community-dwelling older adults aged ≥ 71 years in managing medications. Medications with ≥ 28 days of supply in the prior 6 months were included. Regimen complexity was assessed using the Medication Regimen Complexity Index (MRCI), calculated as the sum of dosage form and dose frequency scores (e.g., tablet 1 + once-daily 1 = 2). The outcome was caregiver-reported medication management difficulty (no/little vs. somewhat/very). Analyses were survey-weighted and logistic regression models were used adjusting for caregiver and care recipient sociodemographic and health characteristics.

Results: The sample included 435 caregivers (weighted = 4.6 million) assisting 435 older adults. A higher MRCI score was significantly associated with greater odds of caregiver-reported difficulty (aOR = 1.05, 95% CI, 1.00–1.10), such that reducing MRCI by 2 points (e.g., three-times-daily to once-daily) would lower the odds of difficulty by about 10%. The average MRCI score was 20.4 (95% CI, 18.8–21.9), consistent with moderate-to-high regimen complexity in prior studies. Caregivers had a mean age of 62.0 years (95% CI, 60.1–63.9); 66.3% were female, and nearly half (48.3%) were adult children. Care recipients had a mean age of 82.0 years (95% CI, 81.2–82.7) and used average of 7.7 medications (95% CI, 7.2–8.3), with mean dosage form and dose frequency scores of 9.5 (95% CI, 8.7–10.3) and 10.8 (95% CI, 10.1–11.7), respectively. Although most prescriptions were oral (85.6%), and once-daily dosing was common (69.3%), nearly one-third (29.7%) required twice-daily or more frequent dosing.

Conclusions: Higher medication regimen complexity was associated with greater caregiver-reported difficulty in medication management. Approaches that streamline medication use—through schedule simplification, formulation changes, or deprescribing—may alleviate caregiver burden.

Paper Session PLENARY

Thursday, April 30
11:15 am – 12:00 pm

P5

Sacubitril/Valsartan Use Across Transitions between Community, Hospital, and Skilled Nursing Facility Settings

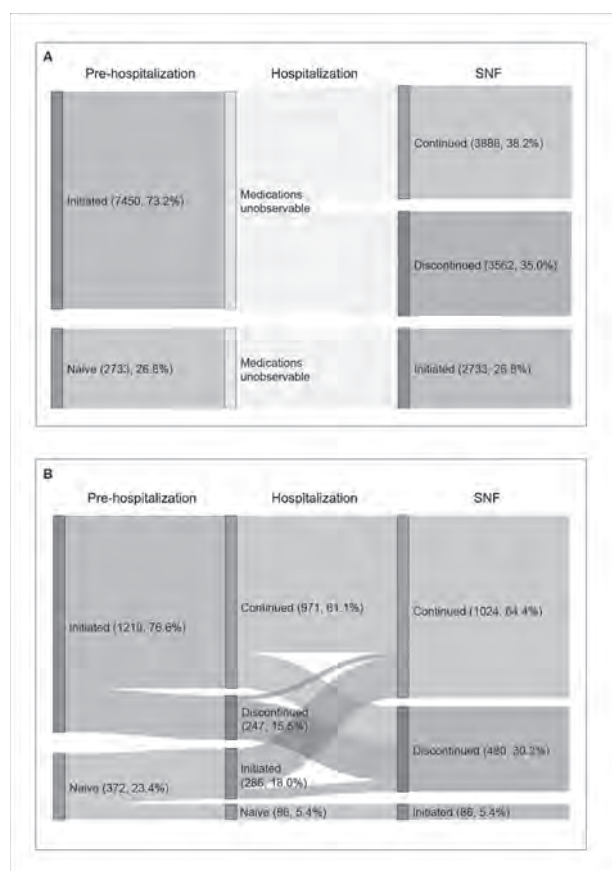
A. R. Zullo,¹ K. Corcoran,¹ D. Lo,¹ L. Resnik,¹ T. Shireman,¹ P. Goyal.² 1. Brown University, Providence, RI; 2. Weill Cornell Medicine, New York, NY.

Background: Sacubitril/valsartan, an angiotensin receptor–neprilysin inhibitor (ARNI), improves outcomes in heart failure (HF), yet use in hospital and ambulatory settings remains low. Use in the post-hospitalization skilled nursing facility (SNF) setting is poorly characterized. We described ARNI use among older adults transferred to SNFs after HF hospitalization.

Methods: We conducted a retrospective parallel cohort study of older adults with HF discharged to SNFs in the Long-Term Care Data Cooperative (LTCDC) or Veterans Health Administration (VA). ARNI exposure was assessed from 1 year before hospitalization through 100 days after SNF admission.

Results: We identified 187,878 LTCDC and 19,817 VA patients discharged to SNFs. Mean (SD) age at SNF admission was 80.0 (8.0) years in LTCDC and 77.8 (7.9) years in VA. Overall, 5.4% (10,183/187,878) of LTCDC and 8.0% (1,590/19,817) of VA patients were exposed to ARNI. Among those exposed before SNF admission, 47.8% (3,562/7,450) of LTCDC and 31.9% (480/1,504) of VA patients received no ARNI during the SNF stay (Figure).

Conclusion: ARNI use is infrequent among older adults discharged to SNFs after HF hospitalization, and discontinuation during the SNF stay is common. These patterns may reflect individualized prescribing in a high-risk population, missed opportunities to optimize therapy, or both.



Panel A, LTDC; Panel B, VA.

P6

Effectiveness of pharmacist-led telemedicine deprescribing vs. usual care for older adults with cognitive impairment: A pragmatic randomized clinical trial

A. Green, R. Quiles, J. Merrey, J. Chou, H. Blum, A. Pagliocchini, Y. Deng, Q. Xue. *Johns Hopkins, Baltimore, MD.*

Deprescribing strategies are needed for people with cognitive impairment. This study evaluated the effectiveness of ALIGN, a pragmatic pharmacist-led deprescribing intervention for older adults with cognitive impairment in primary care.

Patients aged ≥ 65 with mild cognitive impairment (MCI) or dementia and ≥ 5 medications were enrolled 5/24-10/25. Twenty-one community-based Maryland primary care clinics were cluster-randomized to intervention or waitlist control. ALIGN included: 1) a deprescribing brochure for patients/caregivers, 2) a telehealth visit with a clinic pharmacist; and 3) pharmacist-PCP communication with tailored recommendations. The primary endpoint was deprescribing at 3 months. Secondary outcomes included deprescribing of central nervous system-active potentially inappropriate medications (PIM) and initiation of new medications. Poisson regression models were fit to estimate adjusted relative risks (aRR) and 95% CIs, accounting for pharmacist-level clustering and adjusting for baseline medication count and PIM.

Of 1640 patients contacted, 360 (22%) scheduled a pharmacist visit (214 intervention, 146 control). The mean age was 78 (SD 7.3); 259 (72%) had MCI and 101 (28%) had dementia. Participants took 13.8 (SD 6.6) medications on average. At 3 months, in intention to treat (ITT) analysis, 138 (65%) patients in the intervention arm and 73 (50%) in the control had ≥ 1 medication discontinued (aRR 1.27, 95% CI 1.0-1.7, $p=0.10$); 149 (70%) and 87 (60%), respectively, had

≥ 1 new medication added (aRR 1.16, 95% CI 0.89-1.51, $p=0.28$). Additionally, 32 (15%) intervention patients and 10 (7%) controls had ≥ 1 PIM discontinued (aRR 1.99, 95% CI 0.97-4.07, $p=0.06$); 28 (13%) and 18 (12%), respectively, had ≥ 1 new PIM added (aRR 1.12, 95% CI 0.61-2.04, $p=0.72$). There was no difference between arms in change in total medication count.

This pharmacist-led clinical trial in primary care did not significantly reduce overall or PIM prescribing in people with cognitive impairment in ITT analysis, assessing effectiveness regardless of compliance. Between-group differences, though not statistically significant, were clinically meaningful, suggesting efficacy when implemented as intended. Future studies should focus on improving uptake.

P7

Measuring Hospitalization, Deaths, and Hospice Care from Skilled Nursing Facility Electronic Health Records vs. Medicare Claims

C. Santostefano, V. Mor, E. White. *Health Services, Policy, and Practice, Brown University School of Public Health, Providence, RI.*

Background: The Long-Term Care (LTC) Data Cooperative assembles electronic health record (EHR) data from skilled nursing facilities (SNFs) and assisted living communities for research and other uses. Data are from two national EHR vendors and can be linked with Medicare claims via the NIA LINKAGE Program. Our objective was to validate measures of hospitalization, death, and hospice care in the EHR data vs. Medicare claims.

Methods: We used the LTC Data Cooperative dataset published July 2025, which included 2894 SNFs from 48 states plus DC; and 2019-2023 Medicare claims and encounter records. We included residents in participating SNFs with a 1:1 match to the Medicare Master Beneficiary Summary File (MBSF). We constructed three outcome-specific cohorts for hospitalizations, date of death, and hospice care. Within each cohort, we matched available EHR documentation at the person-level to concurrent Medicare claims for that outcome. With this intersection we calculated the share of EHR-measured events with a corresponding claim and, vice versa, the share of claims-measured events with a corresponding EHR record.

Results: 92.9% of EHR-identified hospital stays matched to an inpatient, emergency department, or observation claim, with higher match rates for stays more than 2 days (95.4%) vs. 1-2 days (85.5%). Match rates were comparable for traditional Medicare and Medicare Advantage enrollees, and did not vary significantly across SNFs. 95.4% of claims-identified hospital stays matched to EHR records, meaning the EHR data missed 4.6% of hospitalizations. Among EHR-identified resident deaths, 96.9% matched the MBSF date of death exactly while 3% had a date mismatch. Among MBSF-identified deaths, 97.9% had an exact date match to EHR records and 1.3% had a date mismatch. 98.3% of EHR hospice episodes overlapped with a hospice claim, but only 71.5% of hospice claims had a corresponding EHR record.

Conclusions: We observed high levels of agreement between the LTC Data Cooperative SNF EHR data and person-matched Medicare claims for hospitalizations and deaths, suggesting that the EHR data could reasonably be used as is for these measures, providing a more timely data source than claims. Hospice care was more often missing from EHR documentation, and thus is best measured from claims.

Paper Session GERIATRIC EDUCATION

Thursday, April 30
1:15 pm – 2:15 pm

P8 Encore Presentation

Exploring Users' Perspectives of the Driving and Dementia Roadmap

G. Naglie,^{1,2} E. Stasiulis,³ C. Pilienci,³ M. Rapoport.^{4,2}

1. Baycrest, Toronto, ON, Canada; 2. University of Toronto, Toronto, ON, Canada; 3. Rotman Research Institute, Toronto, ON, Canada; 4. Sunnybrook Health Services Centre, Toronto, ON, Canada.

Background: Since October 2022, the Driving and Dementia Roadmap (DDR) (www.drivinganddementia.ca) – an online resource to support people with dementia (PWD), family/friend carers (FCs), and healthcare providers (HCPs) as they navigate the challenges of driving cessation – has been accessed by over 43,000 users. To understand the DDR's impact we are conducting ongoing surveys to explore users' perspectives.

Methods: As users exit the DDR, they are invited, via pop-up message, to participate in an online survey about their experiences with the DDR, including their perceived new knowledge and confidence gained due to using the DDR and their satisfaction with it. Descriptive statistics were conducted via the REDCap platform.

Results: To date, 117 DDR users have participated in the survey (20 PWD, 45 FCs and 52 HCPs). The highest rated topics for new knowledge gained included: for PWD, "recognizing unsafe driving" (15.8%), "getting around without driving" (15.8%) and "learning about licensing and reporting" (15.8%); for FCs, "learning about licensing and reporting" (56.8%) and "recognizing unsafe driving" (50.0%); and for HCPs, "providing support after driving cessation" (59.6%) and "having discussions and managing emotions" (51.9%). The highest rated topics for increased confidence included: for PWD, "making the decision to stop driving" (52.6%) and "recognizing unsafe driving" (47.3%); for FCs, "initiating conversations about driving cessation" (63.7%) and "making the decision to stop driving" (63.6%); and for HCPs, "managing the emotional impact" (75.0%) and "having conversations about driving cessation" (73.1%). Users also indicated being satisfied with all aspects of the DDR, including "trustworthiness of the information", which was rated the highest (PWD: 77.8%; FCs: 90.9%; HCPs: 90.4%).

Conclusions: These ongoing results indicate that the DDR was considered a trustworthy resource and that using the DDR led to gains in new knowledge and increased confidence in managing aspects of driving cessation for all 3 groups, but least so for PWD. The next step will involve in-depth interviews with participants to better understand the user experience and the relatively lower ratings among PWD.

P9 Student Presentation

Feasibility and Efficacy of Advance Care Planning Pop-Ups among Urban, Community-Dwelling Older Adults

K. Mak,¹ J. Graupner,¹ Z. Huang,¹ R. Kropiewski,¹ M. Malec,¹ T. Gooden,² K. Thompson.¹ 1. The University of Chicago, Chicago, IL; 2. Loyola University, Chicago, IL.

Background: Advanced care planning (ACP) is the process of documenting future healthcare preferences prior to incapacitating illness. The Illinois Department of Public Health provides four advanced directive documents (Power of Attorney (POA), Living Will, Practitioner Orders for Life-Sustaining Treatment (POLST), Mental Health Treatment Declaration (MHTD)) and completion of these can improve care concordance with patient wishes. While patients report desiring conversation surrounding end of life wishes, ACP uptake remains low among older adults.

Methods: We designed a two-part community-based educational intervention (ACP "Pop-Up") to increase ACP awareness and completion of advanced directive documents among older adults in Chicago. Participants were invited to attend 1) a group informational session introducing ACP followed by 2) an additional private consultation for their personalized documents. Surveys were administered to participants pre-post programming at both informational and consultation follow-up.

Results: 75 people attended informational sessions (mean age 75.6), and following this, 28 attended an additional private consultation. Not only was this programming rated highly on quality (n=28; Avg: 9.6, 10-Point Likert), relevance (Avg: 4.6, 5-Point Likert), and organization (Avg: 4.9, 5-Point Likert), but it also yielded effective document completion.

Prior to consultation, nearly half of consultation attendees had completed no documentation (43%). Nearly all attendees (92.9%) went on to complete some documentation, with completion rates being highest for POA (78.6%), followed by Living Will (75%), POLST (71.4%), and MHTD (21.4%).

Overall, we saw a 10-fold increase (7% to 75%) in participants who had completed a majority (>3) of advanced directive documents.

Conclusions: The early success of the ACP Pop-Ups demonstrates program feasibility and replicability as an innovative way for older adults to engage with and complete advanced directive documentation in a community setting.

P10

A Virtual Geriatric Case Competition Offers a Scalable Activity for Health Science Students to Achieve Interprofessional Collaboration Competencies

K. Talley, R. Williams, C. Cauble, T. Schicker. Northstar Geriatric Workforce Enhancement Program, University of Minnesota, Minneapolis, MN.

Background: Scalable educational experiences building interprofessional collaboration competencies are needed for health professional students to treat medically complex older patients. To this end, the University of Minnesota's Northstar Geriatric Workforce Enhancement Program offers an annual multi-institution virtual geriatric case competition. We share the experiences and outcomes of our 2025 competition.

Methods: Multidisciplinary teams of 5-6 students, each guided by a coach, developed and presented care plans addressing a simulated, complex geriatric case. Students completed pre- and post-competition self-ratings of interprofessional competency using the Interprofessional Collaborative Competency Attainment Survey (ICCAS), with dependent t-tests measuring changes in attainment. Judges rated care plans using a rubric based on the Core Competencies for Interprofessional Collaborative Practice. Coaches rated student achievement of four interprofessional competencies from poor to excellent using a 5-point Likert scale. Surveys collected participant feedback on the experience, format and logistics using 5-point Likert scales ranging from poor to excellent and open-ended questions.

Results: From 9 universities, we enrolled 187 health professional students, 32 coaches and 29 judges representing 13 disciplines. Students' mean(SD) score for the ICCAS was 3.16(.63) pre-competition and 4.05(.77) post-competition (t=-6.9, p <.001). The mean(SD) team score from the judging rubric was 82(17) out of a maximum of 110. Coaches mean(SD) score for student interprofessional competencies was 4.37(.75). Half of participants (n=79) had a good or excellent experience, and 31% had an average experience. Students resoundingly indicated that the most valuable part of the competition was the value of working with other professions and learning about their profession's language, and approach to care.

Conclusions: The virtual case competition successfully served as a positive and stimulating educational environment, effectively introducing health professional students to team-based geriatric care.

This structured experience facilitated the attainment of critical inter-professional competencies among the participants.

P11

Evidence-based Approaches for People Living with Dementia: An Educational Strategy for Healthcare Professionals

K. Davis,¹ C. Jensen,² H. Chartrand,¹ A. Rhodes.¹ 1. *Virginia Commonwealth University, Richmond, VA; 2. Riverside Health, Williamsburg, VA.*

Background: There is an identified need to train Emergency Medical Services (EMS), Adult Protective Service (APS), and Department of Corrections (DOC) health professionals in best practices for people living with dementia (PLWD). Therefore, we partnered with personnel from these agencies to deliver dementia education. Agencies emphasized the importance of learning de-escalation, therapeutic communication, and helping families access community resources. Objective: Healthcare professionals who deal with PLWD will have the knowledge, skills, and confidence to deliver evidence-based care during crisis and emergency response.

Methods: A total of nine training sessions were delivered in 2024-2025: eight educational sessions focused on providing care to PLWD during emergency response; and 1 session focused on care for PLWD who are incarcerated. A mixed methods analysis was incorporated. After the training, participants completed a survey (n=175), including demographics, usefulness and relevance of training content (5-point Likert Scale), and intention to make a change in clinical practice. Out of 175 participants, two were emergency medicine physicians, 63 first responders/EMTs/paramedics, 14 office/support staff/911 dispatchers, 69 others (e.g., APS, chaplain, home health, social worker, qualified mental health professional), and ten identified "my work being not healthcare related." Seventeen didn't report professions.

Results: 83% of the participants intended to make a change in their practice after attending the training. 97.1% of the participants strongly agreed or agreed the training content was useful to their work and 88.6% strongly agreed or agreed the training was relevant to them. Themes in the qualitative responses include: increased awareness ("encourage higher levels of patience for myself and others in working with patients having cognitive impairments"), utilizing new techniques/adjusting approach ("Beers Criteria, and standard approach to potential dementia patients"), and distributing resources ("I am going to share with phase training at my facility").

Conclusions: Positive results signify the importance of expanding this educational opportunity. To improve patient outcomes, further research is needed to explore barriers to evidence-based approaches to de-escalation and management strategies in PLWD.

Paper Session

EQUITY, ACCESS, AND AGING: MEETING OLDER ADULTS WHERE THEY ARE

Thursday, April 30

3:45 pm – 4:45 pm

P12 Student Presentation

Anticipatory Grief Experiences of Rural Caregivers of Persons Living with Dementia: A Qualitative Analysis

N. Chu,¹ J. Santoyo-Olsson,² V. Yank.² 1. *University of California Irvine, Irvine, CA; 2. University of California San Francisco, San Francisco, CA.*

Background: Anticipatory grief is sorrow and emotional turmoil experienced prior to death and resulting from the expected loss of a loved one. Severe anticipatory grief among caregivers of persons living with dementia (PLWD) is associated with caregiver

morbidity and a higher likelihood of transitioning PLWD to long-term care settings. This study aimed to explore how rural family caregivers of PLWD experience anticipatory grief.

Methods: This study was a secondary analysis of qualitative data from a nationwide randomized controlled trial of an online family caregiver workshop. Participants across 10 workshops interacted through threaded discussion board posts where they shared experiences, asked questions, and offered support. We performed thematic analysis of 4768 discussion posts.

Results: Among 241 participants representing all U.S. Census regions, 44% cared for a spouse, 44% a parent, 7% other relative, and 5% non-relative. Mean age was 62.3 (SD 11.3), and 86% identified as White, 4% Black, 4% Hispanic, 2% Native American, and 2% Other race. Thematic analysis revealed six themes: grief not validated or understood by others; accumulation of losses over time; mourning for the past; guilt intertwined with heartache; cherishing life together; and acceptance of situation and future decline. Many participants described how their grief was not socially recognized or understood by family and friends. As dementia progressed, participants bore the repetitive, accumulating losses of the PLWD's abilities and their own lost freedoms while anticipating future losses. They mourned the past, expressing heartbreak over the decline in their relationship with the PLWD and the loss of shared activities. Guilt frequently intertwined with grief and other emotions, as participants tried to balance their personal needs and feelings of resentment with their caregiving responsibilities. Despite these challenges, some participants cherished time spent together with the PLWD by revisiting shared memories and living in the moment. Others reached a place of acceptance and peace with their situation and their loved ones' anticipated death.

Conclusions: Findings highlight the complexity and impact of pre-bereavement grief experiences among rural family caregivers of PLWD. Efforts to raise awareness and support for caregiver grief experiences may enhance family caregiver well-being.

P13 Student Presentation

Racial & Ethnic Differences in Analgesic Prescribing for Older Adults with Cancer Before and After 2016 CDC Guideline

E. Rueppel, L. Li, M. Aldridge, K. McKendrick, S. Morrison, R. Rodin. *Brookdale Department of Geriatrics, Icahn School of Medicine at Mount Sinai, New York, NY.*

Background

Opioids are essential for cancer pain management, yet racial and ethnic disparities in analgesic prescribing persist. The 2016 CDC opioid guideline may have reduced appropriate access to opioids for people with cancer and shifted prescribing toward gabapentinoids (1), but effects across diverse groups are unknown. We aimed to measure opioid and gabapentinoid prescribing among multiple racial and ethnic groups of older adults with advanced cancer and to assess whether the guideline differentially affected these trends.

Methods

Using 100% Medicare claims data (2012-2021), we measured opioid (typical opioids, tramadol, buprenorphine) and gabapentinoid (gabapentin, pregabalin) prescribing among adults aged ≥65 years with advanced cancer before and after the 2016 CDC guideline, stratified by race/ethnicity. Difference-in-differences models estimated relative changes by race/ethnicity, adjusted for Medicaid eligibility.

Results

Among 3,216,867 older adults with advanced cancer (mean age 75.3 years; 51.8% female), 80.3% identified as White, 9.0% Black, 5.6% Hispanic, 2.8% Asian, 0.3% (n=10,651) Native American, and 1.8% Other. Pre-guideline opioid prescribing ranged from 66.3% (Native American) to 45.1% (Asian). All groups showed post-guideline declines in opioid prescribing (-8.6 to -10.8 percentage points [pp]). Gabapentinoid use increased across all groups (+2.5 to +6.0 pp; highest in Black [+6.0 pp] and Native American [+4.4 pp] participants).

In adjusted analyses, Black vs. White participants had slightly higher odds of receiving an opioid post-guideline (OR 1.02; 95%CI 1.01-1.04); other groups showed no differential changes. For gabapentinoids, Black, Hispanic, and Asian participants had marginally greater increases than White participants (all ORs 1.1; $p < 0.01$).

Conclusion

In this first national study across multiple racial and ethnic groups with advanced cancer, opioid use declined, and gabapentinoid use rose after the CDC guideline, but differential changes were small and not clinically meaningful. Further research is needed to understand the drivers of inequities in cancer pain treatment.

(1) Rodin R, Li L, McKendrick K, et al. The 2016 CDC Opioid Guideline and Analgesic Prescribing Patterns in Older Adults With Cancer. *JAMA Netw Open*. 2025;8(5):e259043.

P14

Association of Gut Microbiome with Hypertension in Puerto Ricans

A. M. Rivera Castro,^{1,2} 1. Internal Medicine, University of Puerto Rico School of Medicine, San Juan, Puerto Rico; 2. Microbiology Department, University of Puerto Rico School of Medicine, San Juan, Puerto Rico.

Background: Hypertension (HTN) affects 42.2% of Puerto Rican adults, exceeding U.S. averages. Emerging evidence suggests gut microbiota may contribute to HTN through inflammatory, metabolic, and autonomic pathways; however, Caribbean Hispanic older adults remain underrepresented in microbiome studies. This study examined whether microbial diversity or specific bacterial taxa were associated with HTN in older Puerto Rican adults.

Methods: A secondary analysis was conducted on 99 adults aged 55 to 94 who were enrolled in a cross-sectional aging study. Hypertension (HTN) status was determined based on clinical history. Fecal samples were analyzed using 16S rRNA sequencing. Alpha diversity was assessed using the Shannon index, while beta diversity was evaluated with Bray-Curtis metrics. Statistical comparisons were made using the Mann-Whitney U test, ANOSIM, PERMANOVA, and PERMDISP. Additionally, associations between selected bacterial taxa and hypertension were examined through logistic regression.

Results: HTN was present in 76 participants (76.8%) and absent in 23 (23.2%). No significant associations were observed between HTN and the relative abundance of *Blautia* ($p = 0.70$), *Prevotella*, or the *Ruminococcus torques* group. Alpha diversity was significantly lower in hypertensive individuals ($p = 0.044$), while beta diversity showed no group differences (ANOSIM $p = 0.262$; PERMANOVA $p = 0.111$; PERMDISP $p = 0.808$).

Conclusions: Participants without hypertension demonstrated a richer and more diverse gut microbiota, suggesting that greater microbial diversity may offer a protective effect against elevated blood pressure. Although no specific taxa were significantly associated with hypertension status, these findings underscore the relevance of overall microbial diversity in understanding hypertension risk. Ultimately, this work highlights the critical need for larger, well-powered studies in Caribbean Hispanic populations to deepen our understanding of microbiome-cardiometabolic relationships and promote health equity.

P15

Financial Hardship and Quality of Life: Dementia Care Costs in LGBTQ+ and Non-LGBTQ+ Populations

S. Bybee,¹ J. Telonidis,¹ N. Fleming,¹ K. B. Dassel,¹ H. Hedges,¹ J. Guo,¹ E. Iacob,¹ T. Andersen,¹ F. Wilson,¹ J. Flatt.² 1. University of Utah, Millcreek, UT; 2. University of Nevada, Las Vegas, NV.

Background: Alzheimer's disease and related dementias are among the most expensive diseases, with costs primarily borne by persons living with dementia (PLWD) and their care partners. Lesbian, gay, bisexual, transgender, queer, and other sexual and gender

minorities (LGBTQ+) experience greater financial hardship than non-LGBTQ+ peers. Given associations between financial hardship and worse physical and mental health, this study aimed to develop an inclusive dementia-focused financial hardship measure for LGBTQ+ and non-LGBTQ+ PLWD and their care partners. **Methods:** We conducted three 90-minute focus groups with 1) aging and LGBTQ+ health professionals ($n=7$), 2) non-LGBTQ+ PLWD and care partners ($n=8$), and 3) LGBTQ+ PLWD and care partners ($n=5$). Informed by the Financial Hardship Typology, items were modified from the Comprehensive Score for financial Toxicity (COST) used in oncology and generated via literature review. Participants discussed each item's relevance and completed post-focus group questionnaires rating items on a 4-point Likert scale (0=Not Important, 3=Extremely Important). Focus groups were recorded, transcribed verbatim, and analyzed using qualitative content analysis. We calculated descriptive statistics on Likert responses. **Results:** Participants were age 18-25 ($n=1$), 26-49 ($n=4$), 50-64 ($n=7$), and 65+ ($n=8$). Reduced or lost income by patient or care contributor was rated extremely important by all LGBTQ+ and non-LGBTQ+ dyads. For LGBTQ+ dyads, other top-rated items were inpatient/outpatient visits, employment status changes, medical debt/bankruptcy, and worsening quality of life. For non-LGBTQ+ dyads, paid help was most important alongside reduced/lost income. LGBTQ+ dyads emphasized financial hardship's impact on quality of life, describing selling property and possessions and geographic relocation to manage increasing strain. Non-LGBTQ+ dyads emphasized employment changes and effects of dementia expenses on their purchases, bill payment, and resulting psychological distress. **Conclusions:** These findings highlight the importance of sampling traditionally understudied populations for diverse perspectives. Results will inform development of a financial hardship measure capturing dementia's financial impact across diverse PLWD and care partners.

Paper Session

BETTER TOGETHER: TEAM SOLUTIONS FOR BETTER GERIATRIC CARE

Friday, May 1

10:00 am – 11:00 am

P16

Annual Wellness Visit Compliance Rate in an Academic Geriatrics Practice: A Quality Improvement Initiative

S. Tehranian, a. gordon, G. Singh, J. Goldsmith, S. D. McBain, R. Ahmed, P. Solomon, B. Acevedo Mendez. *Northwell Health, New Hyde Park, NY.*

Background: Annual Wellness Visits (AWVs) are an important component of preventive care in older adults, offering opportunities for health maintenance, advance care planning, cognitive assessment and closing gaps in care. National claims data from 2019 indicate that 37.3% of eligible Medicare beneficiaries aged 65 and older completed an AWV. Aim is to improve AWV compliance through low-resource, targeted interventions focused on staff engagement and provider education.

Methods: A single practice site with geriatricians, nurse practitioners, and interprofessional trainees implemented a two-step quality improvement initiative in July 2025. Intervention 1 focused on staff awareness and workflow optimization. This included non-clinical education on patient eligibility, EHR optimization, and mail and electronic outreach to schedule AWVs. Intervention 2 emphasized provider education and involvement. Educational materials were provided to physicians and nurse practitioners on AWV scheduling, documentation, and billing practices. Intervention training included 10 attending physicians, 5 secretaries, and 7 geriatrics fellows, who reviewed patients

and identified opportunities to convert upcoming scheduled visits to AWWs. The target is to reach 37.3% compliance by June 2026, which would align with national benchmark data.

Results: In 2024, 577 of 3,664 eligible patients (16%) completed AWWs in the practice. From January to June 2025, 314 (16%) of 1,940 eligible patients completed an AWW. Similar primary care practices in the health system achieved 67% completion (13,174 AWWs among 19,417 patients) with the top practice completing 83% of AWW from January to June 2025. Data collection is ongoing from June to December 2025, with post-intervention data pending.

Conclusions: This review demonstrates a substantial gap between the target practice performance compared to peers within our system and national data. This 16% completion rate over recent years reflects a significant opportunity for improvement. Targeted, low-cost, resource-efficient interventions designed to improve patient care can bridge this gap and drive unrealized revenue opportunities.

P17

Measuring Functional Status among Older Veterans in Primary Care: Implementation Outcomes of a Hybrid Type II Trial

R. Brown, G. Krautner, K. Zamora-Rogoski, L. Ashcraft, M. Groot, J. Prigge, B. Kinosian, C. Schubert, H. Moriarty, S. Chhatre, M. Wilson, A. Orkaby, A. Schwartz, F. Nicosia. *Department of Veterans Affairs, Philadelphia, PA.*

Background:

Functional status is important for clinical care and outcomes in older adults, yet the ability to perform basic activities of daily living (ADLs) and instrumental ADLs (IADLs) is seldom routinely measured in non-geriatrics primary care settings. We examined if a multi-component intervention implemented in VA primary care increased identification and management of functional impairment in older patients.

Methods:

We conducted a 12-month hybrid type 2 implementation-effectiveness cluster-randomized adaptive trial at 8 sites. The intervention included annual nurse screening of patients ages ≥ 60 and primary care provider (PCP) assessment and referrals of patients with identified impairment. From 0-3 months, sites received "standard" implementation including site-level audit and feedback. At 3 months, sites with $< 80\%$ of eligible patients screened and/or assessed were randomized to continued standard vs. "enhanced" implementation (standard plus clinician-level audit and feedback). At 6 months, sites were cross-allocated. From 9-12 months, all sites received standard implementation. EHR data and periodic reflections measured reach and adoption (proportion of clinicians screening/assessing $\geq 80\%$ of eligible patients).

Results:

Of 9389 eligible patients, 9292 (99.0%) were screened, of whom 1097 (11.7%) were positive for functional impairment; 4.8% had difficulty or needed help with ≥ 1 ADLs, and 9.7% had difficulty or needed help with ≥ 1 IADLs. Of those screening positive, 455 (42%) were assessed by a PCP within 7 days. Of these, 147 received ≥ 1 referrals, 146 were found not to need a referral, and 162 declined a referral. Most referrals were for social work (89), physical therapy (36), and geriatrics (32). Screening and assessment reach were similar at 3 and 9 months (99.2% vs 98.7%, $p=.09$; 37.3% vs 48.0%, $p=.07$). Only 46% of participating PCPs adopted the intervention vs. all nurses. Clinicians reported that the intervention improved detection of patients' functional needs but noted operational and technological barriers to timely assessment by PCPs.

Conclusions:

These findings suggest that this intervention increases identification of functional impairment in primary care, but that additional strategies are needed to improve rates of PCP assessment.

P18

Melodies for the Mind: Implementing a Nurse-Driven Personalized Music Playlist Intervention for Hospitalized Older Adults

J. Sharninghausen,¹ K. Faherty,^{2,1} A. Abbagnaro,¹ C. Bursey,¹ J. Li,¹ S. Ruser,¹ R. Marottoli.^{1,3} 1. *Yale School of Medicine, New Haven, CT*; 2. *School of Nursing, University of Connecticut, Storrs, CT*; 3. *VA Connecticut, West Haven, CT.*

Background: Older adults admitted to the hospital are vulnerable to delirium and functional decline. Therapeutic music can help decrease anxiety, improve mood, and support mobility. Our inpatient geriatric medicine unit initially established a personalized music playlist program with trained student volunteers. Over time, to increase sustainability, we shifted to a nurse-driven model.

Methods: A nurse educator collaborated with program leaders to develop a structured, monthlong music-awareness initiative. This interdisciplinary effort engaged nursing staff and students and medical trainees. Nursing teams received emails, hands-on education, and daily reminders in huddles. For medical teams, brief education and dot phrases were added to trainee orientation. The importance of selecting patients' preferred music was emphasized. Staff were encouraged to submit QR-code surveys to track patients' music playlist use and observations. Three tablets with a music playlist app were used.

Results: 56 survey entries were submitted by 22 unique staff members, primarily nursing (RN, CNA, students). Of the entries, 32% described patients' first time with the music intervention; many listened multiple times. Staff reported that listening to preferred music helped improve patient mood (68% of recorded observations), calm down or redirect difficult behaviors (59%), avoid as-needed medication for agitation (39%), engage in basic activities or care (34%), and avoid physical restraints (13%). Free text observations included stories of transformation from severe emotional distress to singing, dancing, reminiscing, or calming down and sleeping. Nursing staff described how engaging with music also enhanced connection between staff and patients. On a separate nursing staff survey ($n=13$), 77% agreed that they enjoyed helping patients listen to their favorite music. Regarding barriers, 62% cited insufficient tablet availability. Suggestions included improving processes to share and save personalized playlists.

Conclusions: Through staff engagement strategies, this initiative integrated therapeutic music use in a geriatric medicine unit. We demonstrate how nurses and interprofessional trainees can lead practice change, support delirium reduction, and collaborate to improve patient care.

P19

Nursing Staff's Response to Incorporating a Multi-Modal Sleep Hygiene Bundle to Reduce Incident Delirium in Older Adults

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Background:

Poor sleep is a risk factor for delirium in hospitalized older adults. A Multi-Modal Sleep Hygiene (MMSH) bundle was implemented to increase sleep (10pm-5am), however the logistic changes may pose a challenge for nursing staff. We examined feedback on the MMSH bundle incorporation into their workflow.

Methods:

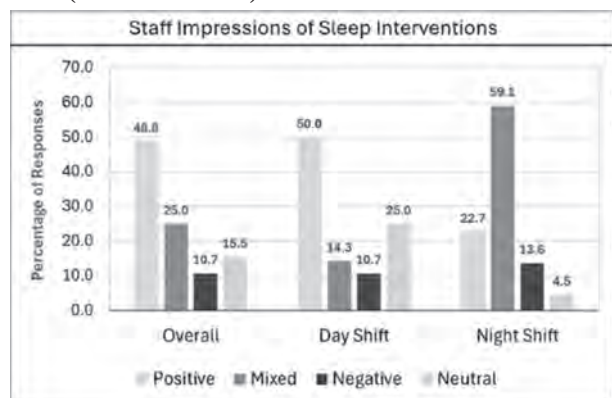
Nursing staff on two acute care units with the MMSH bundle were individually asked "How has it been to incorporate the study interventions into your daily workflow?" between May and August 2025. The overall valence of responses was separately encoded by study staff (MC, CB, and AS) and classified in 4 categories: positive, mixed, negative, and neutral. Independent coders reconciled discrepancies. Thematic analysis was used to determine patterns in responses. Differences in valence across shifts were assessed using Pearson χ^2 tests.

Results:

84 responses were collected from nursing staff: 28-day shift, 22-night shift, 34 shift not indicated (Figure 1). Valence differed significantly across shift ($p=0.005$), with day shift showing a higher proportion of positive responses while night shift more frequently provided mixed. Day shift nurses reported smoother workload, night shift reported falling behind and competing priorities, and both reported better sleep and engagement from patients. Staff liked reduced vital sign times and clustering care but struggled with later morning lab draws and medications.

Conclusions:

The MMSH bundle improved patient sleep but introduced workflow challenges, particularly for night shift. Balancing staff burden with patient benefit is essential for successful adoption. Supported by PCORI (DE-2023C1-31325).

**Paper Session****NEW TOOLS FOR OLD PROBLEMS: ADVANCING FUNCTIONAL ASSESSMENT IN AGING****Friday, May 1****12:15 pm – 1:15 pm****P20 Student Presentation****Exercise Interventions to Improve the Sixth Vital Sign (Gait Speed) in Older Adults: A Systematic Review and Meta-Analysis**

E. Zhou,¹ P. Hewston,¹ C. Schelhaas,² N. Santesso,¹ G. Ioannidis,¹ J. Lee,¹ M. Wang,¹ A. Azizudin,¹ T. Dias Desinghe,¹ H. Khalid,¹ A. Papaioannou¹. ¹ McMaster University, Hamilton, ON, Canada; ² Queens University, Kingston, ON, Canada.

Background: Gait speed, the *sixth vital sign*, is a powerful predictor of health and independence in older adults. Yet, the optimal exercise prescription to improve gait speed remains unclear. We conducted a meta-analysis to evaluate the effectiveness of exercise interventions on gait speed in community-dwelling older adults. **Methods:** We searched for randomized controlled trials (RCTs, 2014–2025) from PubMed, EMBASE, CINAHL, and Cochrane CENTRAL. Inclusion criteria were (i) RCT design, (ii) older adults (aged 60+), (iii) exercise intervention, and (iv) usual gait speed outcome. We assessed risk of bias and certainty of evidence using Cochrane RoB-2 and GRADE, respectively. The primary analysis compared mean differences (MD) in usual gait speed between exercise and control groups. Usual gait speed was defined as self-selected walking over 4–10m, reflecting habitual mobility performance in daily life. A change of 0.05 m/s is considered the minimal clinically important difference (MCID) threshold. **Results:** Of 23,411 records screened, 37 RCTs (N = 2,711 participants) met inclusion criteria. Interventions varied in frequency (2–7 sessions/week), intensity (low to high), duration (6–52 weeks),

and type (resistance, balance, endurance, multicomponent, or 3D exercises, e.g., Tai Chi, dance; movement through three spatial planes). Exercise interventions likely increase usual gait speed compared with control (MD = 0.07 m/s, 95% CI: 0.04–0.10), a small but clinically meaningful improvement. Multicomponent programs likely yield the greatest gains (MD = 0.09 m/s, 95% CI: 0.04–0.15), followed by resistance (MD = 0.07 m/s, 95% CI: 0.03–0.11), 3D (MD = 0.07 m/s, 95% CI: –0.05 to 0.23), and balance exercise (MD = 0.06 m/s, 95% CI: –0.02 to 0.15). When compared with no exercise, exercising 2–3 times per week likely yields the greatest gains in usual gait speed (MD = 0.12 m/s, 95% CI: 0.05–0.19). **Conclusion:** Multicomponent, resistance, balance, and 3D exercise interventions lead to moderate clinical improvements of the sixth vital sign in community-dwelling older adults. Identifying exercise types and frequencies associated with the largest gains in usual gait speed provides practical guidance to optimize exercise prescriptions and enhance functional independence for healthy aging.

P21 Resident Presentation**Development of Novel Patient-Reported Outcome Measures for Older Adults Following Hospital Discharge**

C. Morton,¹ A. Higgins,⁵ A. Pusic,⁶ Z. Cooper,¹ R. Bernacki,^{4,2} M. Edelen,⁶ J. Liu.³ ¹ Center for Surgery and Public Health, MassGeneral Brigham, Boston, MA; ² Center for Geriatric Surgery, MassGeneral Brigham, Boston, MA; ³ Department of Surgical Oncology, MD Anderson, Houston, TN; ⁴ Department of Supportive Oncology, DFCI, Boston, MA; ⁵ Patient Reported Outcomes, Value and Experience (PROVE) Center, Boston, MA; ⁶ PROVE Center, Boston, MA.

Background: We have limited understanding of patient experiences following hospital discharge. Leveraging well-validated Patient Reported Outcomes Measurement Information System (PROMIS) item banks, we developed measures of Physical and Social functioning among older adults (≥ 65) after hospitalization.

Methods: We chose candidate items from the PROMIS Physical Function and Ability to Participate in Social Roles and Activities item banks based on face validity and psychometrics. Experts rated the relevance of the items between 1 and 9, with 9 being “Very Relevant.” Highly rated items were presented to older adults in interviews.

Results: 35 Physical and 14 Social Function items were rated by 15 experts (physicians, physical therapists, and patient advocates). 16 Physical and 9 Social Function items (median expert relevance ≥ 7 and ≥ 6 respectively) were presented to 16 patients. 50% of patients were female and 44% were between 70 and 80 years of age. 87% of interviews were conducted virtually with patients at home in the days to weeks following discharge; 13% were conducted in the hospital on the day of discharge. In interviews, patients characterized difficulties after hospitalization that took time to overcome: “I’m making choices to be active outside the home as opposed to staying and making my bed. It’s not like you have a boo-boo and it heals” (PT2). Patients identified 6 Physical and 4 Social Function items as most relevant and described the measures as relevant, comprehensive, and comprehensible.

Conclusions: We have developed two patient-reported outcome measures with strong content validity that assess Physical and Social function after discharge for older adults. The measures will now undergo field testing. Capturing function from the patient perspective is imperative to develop interventions tailored to outcomes that matter to patients.

P22

Relationship Between Pre Critical Illness Handgrip Strength and Post Critical Illness Disability

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 1. Medicine, Ohio State University, Columbus, OH; 2. Center for the Advancement of Team Science, Analytics, and Systems Thinking in Health Services and Implementation Science Research (CATALYST), Ohio State University, Columbus, OH; 3. Neurology, Ohio State University, Columbus, OH.

Background: Low handgrip strength is associated with disability in sepsis survivors, but the relationship in patients admitted to the intensive care unit is unclear.

Methods: Using the National Health and Aging Trends Study (NHATS) linked to Medicare claims, we identified participants with an intensive care unit (ICU) hospitalization. We excluded those with an ICU admission in their first year of participation lacking prior measures of grip strength. We used handgrip strength measurements in the year prior to their ICU hospitalization and post-critical illness disability in the year after ICU hospitalization using a 13-item score assessing basic and instrumental activities of daily living (ADL; higher scores indicate worse disability). Prevalence of low handgrip strength was determined using validated cut-points (<20.0 kg for females, <35.5 kg for males). We used linear regression to assess the association between pre-critical illness handgrip strength and post-critical illness disability, adjusting for prespecified covariates.

Results: We identified 872 ICU admissions that met criteria for analysis with a median age 81 (IQR 76-87) years, 42% female, and Charlson comorbidity index score of 5 (IQR 2-7). Participants had a median grip strength of 18.1 kg (IQR 14.2-22.8) for females and 27.9 kg (IQR 21.8-34.8) for males and a median of 2 (IQR 1-4) ADL disabilities. The prevalence of low handgrip was 71% (n=623). In adjusted models, lower pre-critical illness handgrip strength was associated with greater post-critical illness disability; each 1 kg decrease in grip strength corresponded to a 0.04-unit increase in disability ($\beta = -0.04$, 95% CI [-0.06, -0.02], $p < 0.001$).

Conclusions: Low grip strength was highly prevalent in older survivors of critical illness. Although the per-kilogram effect size is modest, real-world differences in handgrip strength correspond to clinically meaningful differences in post-critical illness disability. These findings support further investigation into interventions that preserve or improve muscle strength as a strategy to maintain independence after critical illness.

P23

Development and Validation of a Severity-Stratified Predictive Model for Undiagnosed Alzheimer's Disease and Related Dementias in the Emergency Department

N. Festa,¹ K. Alexovitz,¹ N. Sifnugel,² I. Cohen,¹ S. Khasnavis,¹ J. Young,¹ M. Iscoe,¹ A. Mecca,¹ L. Han,¹ U. Hwang.² 1. Yale, New Haven, CT; 2. NYU, New York, NY.

Background: Over half of adults with Alzheimer's Disease and Related Dementias (ADRD) are undiagnosed, constraining access to evidence-based care. While the electronic health record (EHR) is a promising resource for identification, current methods have critical limitations. First, existing approaches have been developed within cohorts derived from ambulatory care settings, which underrepresent individuals who rely on episodic acute care and are most prone to underdiagnosis. Second, these approaches are not calibrated to severity, despite the progressive manifestations of ADRD. We developed a predictive instrument to address these methodological and implementation gaps.

Methods: We applied a validated computational phenotype to identify probable ADRD (p-ADRD) and its severity within a random sample of 5,000 individuals aged ≥ 65 years who presented to one of nine emergency departments (EDs) in the Yale New Haven Health

System (2015-2022). This yielded a final cohort of 1,358 individuals with p-ADRD. The dichotomous outcome was undiagnosed ADRD, assigned to those who met criteria for p-ADRD but lacked qualifying diagnostic codes per a validated definition. We applied logistic regression with elastic net regularization to predict undiagnosed status for the overall cohort and by severity, reporting the area under the receiver operating characteristic (AUROC) curve from 10-fold cross-validation.

Results: Of the 1,358 individuals with p-ADRD, 934 (68.8%) were undiagnosed. The prevalence of underdiagnosis decreased with severity (81.5% mild, 64.0% moderate, 29.9% severe). The overall model discriminated undiagnosed ADRD with an AUROC of 0.91 (95% CI 0.90-0.93). Although the predictive features differed by severity, past fall-related injury was protective against underdiagnosis for each stratum. The stratified models achieved an AUROC of 0.85 (95% CI 0.82-0.88) for mild, 0.93 (95% CI 0.89-0.96) for moderate, and 0.85 (95% CI 0.79-0.92) for severe cases.

Conclusions: We developed and validated the first severity-stratified, EHR-based predictive models for undiagnosed ADRD in the ED, which demonstrated good-to-excellent performance. The heterogeneity of predictive features across severity strata underscores the importance of calibrating prediction to the natural progression of ADRD to guide tailored interventions.

Paper Session**CLIN-STAR****Friday, May 1****2:45 pm – 3:45 pm**

P24

Impact of a Geriatric Perioperative Assessment Program in Older Adults

A. Shah,¹ Y. Ummaneni,² O. Han,² S. S. Dara,¹ S. Gelman,¹ A. Sarkar,^{2,1} H. Ross,^{2,1} C. Socci,¹ M. Parulekar.^{2,1} 1. Hackensack University Medical Center, Hackensack, NJ; 2. Hackensack Meridian School of Medicine, Nutley, NJ.

Background:

Major surgery in older adults has substantial risks of prolonged hospitalization, institutional discharge, and mortality. The Geriatric division implemented a Geriatric Perioperative Assessment program (GPAP) in collaboration with the Surgery department at Hackensack University Medical Center. This study evaluates the program's impact.

Methods:

This retrospective cohort study included patients aged ≥ 75 years who underwent inpatient surgery from 2021-2024. Three matched cohorts were analyzed (N=46 each): (1) pre-intervention 2021 (CG1), (2) Group with geriatric assessment 2022-2024 (GA), and (3) Group without assessment 2024 (CG2). The outcomes included length of stay (LOS), readmission, discharge disposition, mortality, inpatient antipsychotic use and postoperative complications. Statistical analysis was done to compare group differences and binary outcomes.

Results:

Patients receiving GA had a significantly shorter LOS (median 2 days, IQR 2-4) than both CG1 (5 days, IQR 2-7) and CG2 (6.5 days, IQR 3-13) groups ($p=0.001$). The GA had a faster time to discharge (HR = 1.68; 95% CI 1.10-2.58), whereas CG1 and CG2 did not differ. Thirty-day readmission rates were similar across groups (13-20%; $p = 0.672$; Table 3), with no differences after adjusting for the Charlson Comorbidity Index. Data demonstrated significantly lower mortality in the GA versus the CG(1&2) (OR = 0.08; 95% CI 0.00-0.77). Thirty-day mortality was 0% in the GA, 11% in CG1, and 6.5% in CG2. Discharge disposition differed across groups ($p=0.004$); the GA had fewer discharges to rehabilitation (6.5% vs 17% and 26%)

and no in-hospital deaths. Post-operative complications were infrequent (11-13% overall, $p = 0.932$) with no significant differences between groups.

Conclusion:

The GPAP was associated with shorter hospital stays, decreased mortality, fewer complications, and improved discharge outcomes among older adults undergoing major surgery. These findings support the collaboration between geriatric medicine and surgery to reduce adverse outcomes in older adults.

P25

High-risk medication prescribing among older adults in the emergency department: a national assessment

S. Follman,¹ M. Canavan,² C. Rothenberg,¹ M. Iscoe,¹ A. Venkatesh,¹ R. Ramachandran,³ C. Gettel.¹ 1. *Emergency Medicine, Yale School of Medicine, Woodbridge, CT*; 2. *Yale Cancer Outcomes, Public Policy and Effectiveness Research Center, Yale School of Medicine, New Haven, CT*; 3. *Yale Collaboration for Regulatory Rigor, Integrity, and Transparency, Yale School of Medicine, New Haven, CT*.

Background: Potentially inappropriate medication prescribing remains a common and preventable source of adverse drug events among older adults, particularly during transitions of care such as emergency department (ED) discharge. We assessed the prevalence and trends of older adults prescribed high-risk medications on the Geriatric Emergency Medication Safety Recommendations (GEMS-Rx) list.

Methods: We conducted a cross-sectional study using the 2017-2022 Merative MarketScan Medicare Supplemental Database. We included ED visits by older adults (65+ years of age) who were discharged from the ED. The primary outcome was met if a GEMS-Rx medication was filled within three days of ED discharge. Multivariable logistic regression estimated associations between patient- and system-level factors and GEMS-Rx fill after ED discharge.

Results: Among 616,980 unique ED visits, 58,284 (9.4%) had a GEMS-Rx medication filled within three days of discharge. In 2017, 13,746 (11%) ED encounters resulted in a GEMS-Rx prescription fill within three days of ED discharge compared to 6,524 (7%) ED encounters in 2022. Benzodiazepines (37%), first-generation antihistamines (22%), and skeletal muscle relaxants (11%) were the most frequently prescribed classes of GEMS-Rx medications. Female sex (OR 1.43, 95% CI 1.41-1.46) and younger age (75-84 years: OR 0.69, 95% CI 0.68-0.71; ≥ 85 years: OR 0.47, 95% CI 0.46-0.48) were associated with higher odds of receiving a GEMS-Rx medication.

Conclusions:

Nearly 1 in 10 older adults filled a high-risk GEMS-Rx medication within three days of ED discharge between 2017 and 2022. Despite a decline in GEMS-Rx medication fills over time, younger cohorts of older adults and females were more likely to fill a high-risk prescription upon ED discharge. These findings highlight opportunities to continue improving geriatric medication safety through targeted education, decision support, and system-level interventions.

P26

Implementation of an automated EHR-based advanced care planning intervention in primary care

S. Nouri, K. Patel, W. J. Boscardin, R. L. Sudore. *University of California San Francisco, San Francisco, CA*.

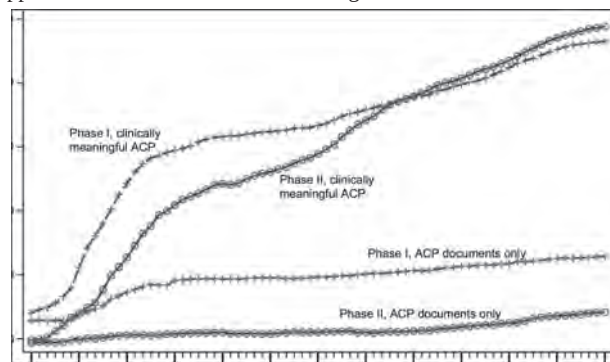
Background: Although research has shown system-level advance care planning (ACP) interventions can increase ACP documentation, implementation in primary care is challenging. We evaluated the impact of an EHR-based intervention consisting of automated patient identification and messaging about the evidence-based PREPARE for Your Care program.

Methods: From 12/2018-12/2024, primary care patients (18+ years with serious illness or 65+) at an academic health system received

EHR messages and letters about PREPARE in 3 clinics in Phase I (2018-2022) and EHR messages in 8 more clinics in Phase II (2022-2024). To assess the outcome of clinically meaningful ACP documentation (i.e., advance directive/POLST, ACP notes, etc.), we used mixed-effects logistic regression (adjusted for age, gender, race-ethnicity, serious illness). To account for secular trends, we excluded participants with prior ACP and conducted Cox proportional hazard models on a propensity-matched cohort comparing those who did vs did not receive the intervention.

Results: Among 26,558 patients, mean age was 72 (SD8), 58% were women, 50% minoritized race-ethnicity, 13% serious illness; 64% of those eligible received the intervention. Overall, significant increases in ACP documentation correlated with intervention implementation in both Phases (Fig). Among patients with no prior ACP ($n=8,551$), those who received the intervention were more likely to have documented ACP vs those who did not (adjusted HR 2.15; 95%CI 2.0-2.3).

Conclusions: Implementation of an automated EHR-based intervention using PREPARE increased ACP documentation in a real-world primary care setting serving diverse populations and can be applied to other resource-limited settings.



P27 Student Presentation

Trends in clinical complexity and outcomes of older adults undergoing inpatient general surgery

C. Yoon,² F. Wang,³ S. Thomas,³ S. Lagoo-Deenadayalan,¹ K. S. Johnson,⁴ H. S. Kazaure.¹ 1. *Surgery, Duke University Medical Center, Durham, NC*; 2. *Duke University, Durham, NC*; 3. *Duke Cancer Institute, Durham, NC*; 4. *Medicine, Duke University Medical Center, Durham, NC*.

Background: Older adults (age 65+) are increasingly undergoing surgery. There is a paucity of data on trends in their clinical complexity and outcomes following inpatient surgery.

Methods: Older adults undergoing inpatient surgery (≥ 1 hospital day) were abstracted from the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) dataset (2006-2022). A 17-year trend analysis of baseline characteristics (e.g., demographics, functional status, frailty measured by the validated modified 5-factor frailty index [mFI-5], American Society of Anesthesiologists [ASA] class) and 30-day outcomes was performed.

Results: A total of 419,583 patients undergoing 11 procedure types were analyzed. Approximately 53.3% were female; mean age was 74.5 years. Over the study period, the proportion of older adults undergoing inpatient general surgery decreased from 75% to 56%; there was a ~16.8% decline among patients aged ≥ 85 years ($p < 0.001$). At baseline, the proportion of older adults who were functionally independent increased from 83.7 to 93.9% ($p < 0.001$), as did the proportion classified as not frail at baseline (mFI < 0.3) (77.0% to 83.0%; $p < 0.001$). Severity of illness at the time of surgery increased, as reflected by rates of emergency surgeries (11.8% to 26.6%, $p < 0.001$) and ASA class III-IV (69.2% to 76.0%, $p < 0.001$). Procedure patterns

shifted toward more complex operations, with increased colorectal (33.5% to 43.3%, $p<0.001$) and pancreatic resections (5.7% to 7.9%, $p<0.001$). The 30-day complication rate showed no significant clinical change (27.0% to 29.0%, $p<0.001$), but there were decreases in postoperative ventilator dependence (58.7%), urinary tract infection (51.5%), and venous thromboembolism (33.3%) ($p<0.001$ for all). The 30-day mortality over the 17-year study period declined by 26.2% from 6.5% to 4.8% ($p<0.001$).

Conclusions: Over time, older adults undergoing inpatient general surgery in ACS NSQIP hospitals have lower baseline frailty but higher perioperative risk, with a trend towards more complex inpatient procedures. Postoperative mortality declined significantly, while complication rates remained relatively stable. These temporal trends suggest a paradigm shift in geriatric surgical care that warrants further research.

Paper Session

BRAIN HEALTH IN CONTEXT: BIOLOGY, DIAGNOSIS, AND CARE DELIVERY

Saturday, May 2

10:00 am – 11:00 am

P28

Whose job is it anyway? Adding a dementia diagnosis in the electronic medical record

K. M. Garcia Ortiz,¹ A. Mirk.^{1,2} 1. Division of Geriatrics and Gerontology, Emory University School of Medicine, Atlanta, GA; 2. Birmingham/Atlanta VA Geriatric Research, Education, and Clinical Center (GRECC), Atlanta, GA.

Background:

The U.S. Department of Veterans Affairs (VA) reports a high prevalence of all-cause dementia, yet prior work demonstrates persistent underdiagnosis and miscoding within the VA Healthcare System (VAHCS) electronic medical record (EMR). This project evaluated patterns of dementia documentation across prescriber specialties and explored provider-reported barriers to documenting dementia.

Methods:

This single-center, retrospective quality improvement project identified active prescriptions for cognitive-enhancing medications including acetylcholinesterase inhibitors or memantine (CEM) between August 1, 2023, and August 1, 2024, in Veterans aged ≥ 50 years. Data from the VA Corporate Data Warehouse included CEM prescriber specialty, encounter-based coding, and problem-list documentation. The primary outcome was the presence of a dementia diagnosis in the EMR at the time of CEM prescription across specialties. Secondary outcomes included provider-reported documentation barriers from an anonymous electronic survey. Analyses were descriptive.

Results:

A total of 1,487 prescriptions met criteria; 765 (51.45%) had dementia listed on the EMR problem list on or before the CEM prescription date. Problem-list documentation varied by specialty: geriatrics 70.81%, psychiatry 52.38%, primary care/home-based primary care 49.69%, other 47.06% and neurology 22.22%. Overall, 76.33 % of encounters with CEM prescribing included encounter-based dementia coding, with highest rates in geriatrics (95.69%), followed by psychiatry (82.54%), primary care/home-based primary care (72.48%), neurology (64.20%), and others (61.76%). Anonymous electronic survey of 53 clinicians across specialties found the most common barriers to adding a dementia diagnosis to the problem list were: defer this to other specialties (56%), unsure of etiology of the dementia at time of visit (37.7%), many diagnostic codes for dementia and unsure which one is correct (17%).

Conclusions:

Half of Veterans prescribed CEM lacked a corresponding dementia diagnosis in the EMR, with substantial specialty-related variation. Findings highlight opportunities for targeted education, workflow improvements, and system-level interventions to strengthen diagnostic accuracy and support high-quality dementia care within the VAHCS.

P29

Building cognitive reserve in older adults with hearing loss - COCHLEA study 72-month outcomes

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BACKGROUND:

Untreated hearing loss is associated with faster cognitive decline in older adults and is a potentially modifiable risk factor for dementia.

Cochlear implants (CIs) significantly improve speech perception/communication and could help to build cognitive reserve in this population, delaying the onset of cognitive decline/dementia. However, there is no high-quality evidence of their effects on cognition.

The Cochlear Implant Outcomes and Cognitive Health – Longitudinal Evaluation of Adults (COCHLEA) is an Australian prospective, longitudinal study investigating cognitive performance in older adults with hearing loss after cochlear implant use compared with that of community-living older adults in the Australian Imaging, Biomarker and Lifestyle Flagship Study of Ageing (AIBL).

METHODS:

Outcomes for 150 new CI users (61-90; mean = 74 years) and 193 community-living AIBL participants (63-94; mean = 76 years) at 18-mth intervals from 18-, 36-, 54- and/or 72-mth points are compared. Cognitive performance was measured using the Cogstate Brief Battery and Groton Maze Learning Test. Cognitive trajectories were analyzed using panel regressions with heteroskedasticity-consistent standard errors clustered at participant level to allow for inter-participant observation dependence. Holm-Bonferroni adjustments were applied for multiple comparisons.

RESULTS:

The CI group significantly improved at 36 and 54 mths on executive function (EF; $p = 0.009$; 0.001) and at 54 mths on working memory (WM; $p = 0.005$). Greatest improvements were at 54 mths; 26% and 1.3% of baseline mean, respectively. Participants who used their devices 14 hrs/day or more showed significantly greater improvement (eg. 39.3% vs 4.9% for EF, 18 mths). There was no decline by 72 mths. Age at implantation did not significantly affect cognitive outcomes, though increased age predicted worse baseline performance across all subtests.

CONCLUSIONS:

Untreated hearing loss has enormous detrimental effects on quality of life and high economic costs to society. These results suggest that CI use can increase cognitive reserve and may reduce/delay dementia incidence, promoting healthy aging. Given low take-up rates, improved knowledge of CIs in the medical profession is needed to successfully implement this intervention at scale.

P30

Age-Friendly Health Systems recognition and days spent at home among hospitalized older adults with dementia

R. Ikesu,⁴ T. Nuckols,¹ S. Rosen,¹ D. Saliba,³ B. McGarry,² A. Walling,⁴ A. Klomhaus,⁴ Z. Feng,¹ Y. Tsugawa,⁴ H. Gotanda.¹ 1. Cedars-Sinai, Los Angeles, CA; 2. University of Rochester, Rochester, NY; 3. VA, Los Angeles, CA; 4. UCLA, Los Angeles, CA.

Background: Many hospitals are now recognized as Age-Friendly Health Systems (AFHS) based on implementation of evidence-based care using the 4Ms framework. Age-friendly care is relevant

among hospitalized older adults with dementia, who often experience adverse drug events, delirium, falls, and functional decline.

Methods: We conducted a quasi-experimental study using difference-in-differences (DID) and event study analyses to compare days at home (DAH) between older adults with dementia who received care in hospitals with vs. without AFHS recognition. We identified hospitalizations of patients aged ≥ 66 years with dementia in 2016–2020 using a 20% sample of Medicare fee-for-service data. DAH was defined as the number of days alive within 365 days from admission date minus days spent in healthcare facilities (i.e., hospitals, emergency departments, observation units, skilled nursing facilities, and long-term care nursing homes).

Results: We included 9,499,540 hospitalizations of patients with dementia, with 943,168 (9.9%) occurring in hospitals with AFHS recognition. The DID analysis found no evidence that patients receiving care in AFHS-recognized hospitals experienced more DAH compared to those in non-AFHS hospitals (DID estimate, +1.9 days; 95% CI, -0.1 to +3.9; $P=0.07$). In the event study analysis, patients receiving care in AFHS-recognized hospitals experienced more DAH in Year 1 post-recognition (event study estimate, +1.8 days; 95% CI, +1.4 to +3.6; $P=0.048$), whereas we found no evidence of difference between the two groups in Year 2 post-recognition (+2.5 days; 95% CI, -0.5 to +5.5; $P=0.10$). Analysis restricted to hospitals with Level-2 (higher tier) AFHS recognition demonstrated significant differences between the two groups: DID estimate, +4.1 days (95% CI, +1.5 to +6.7; $P=0.002$); event study estimate in Year 1, +3.2 days (95% CI, +0.6 to +5.9; $P=0.02$); and in Year 2, +4.4 days (95% CI, +0.2 to +8.6; $P=0.04$).

Conclusions: We found that hospitals' AFHS recognition, particularly at the higher tier, was associated with modestly improved DAH outcome among hospitalized older adults with dementia. Our findings inform the ongoing national expansion of age-friendly care, including a mandatory new Medicare Age-Friendly Hospital Measure.

P31 Student Presentation

Blood Markers of the Renin-Angiotensin System and Brain Volumes in a Longitudinal Study

Y. A. Lee,¹ O. Carmichael,² A. Anderson,³ M. Espeland,⁴ D. J. Asby,⁵ P. Kehoe,⁵ S. Miners,⁵ M. C. Carlson,⁶ S. Yasar.⁷ 1. *School of Medicine, Johns Hopkins University, Baltimore, MD*; 2. *Biomedical Imaging Center, Pennington Biomedical Research Center, Baton Rouge, LA*; 3. *Biostatistics and Data Science, Wake Forest University School of Medicine, Winston-Salem, NC*; 4. *Internal Medicine, Wake Forest University School of Medicine, Winston-Salem, NC*; 5. *Dementia Research Group, University of Bristol, Bristol Medical School, Bristol, United Kingdom*; 6. *Mental Health, Johns Hopkins University School of Public Health, Baltimore, MD*; 7. *Gerontology and Geriatric Medicine, Johns Hopkins University School of Medicine, Baltimore, MD*.

Background: Dysregulation of the renin-angiotensin system (RAS) has been proposed as a potential modifier of Alzheimer's disease (AD) pathogenesis, but longitudinal human data are limited. We examined the association between RAS biomarkers and known clinical indicators for AD.

Methods: Retrospective analysis was performed in 76 community-dwelling, dementia-free Look AHEAD clinical trial participants who had overweight/obesity and diabetes at baseline and were followed up over 12 years. Individuals taking RAS-affecting medications were excluded. Plasma angiotensin-converting-enzyme-1 (ACE-1), ACE-2, angiotensin II (ANGII), and angiotensin 1-7 (ANG1-7) levels were measured at follow-up years 1 and 4. T1-weighted brain MRI images were acquired 10-12 years from baseline. Linear regression was used to examine the association of RAS biomarkers with MRI-based brain volumes, plasma amyloid β (A β 42) levels, and apolipoprotein ϵ 4 (APOE ϵ 4) genotype.

Results: At years 1 and 4, higher ACE-1 levels were associated with smaller hippocampal and grey matter volumes ($p \leq 0.02$). Higher ACE-2 levels at year 1 were associated with smaller grey matter volume ($\beta = -2.32$, 95% CI [-4.06, -0.26], $p = 0.02$). There was a stronger association between higher ACE-1 levels and larger hippocampal, medial temporal, and caudate volumes among those with high A β 42 levels compared to low (interaction $p < 0.05$). Similarly, higher ACE-2 levels at year 1 were more strongly associated with larger grey matter volume among those with higher A β 42 levels (interaction $p \leq 0.03$). No significant associations were observed for ANGI, ANG1-7, or APOE ϵ 4.

Conclusion: Higher ACE-1 and ACE-2 levels were associated with smaller hippocampal and grey matter volumes, and A β 42 modified these effects. These results support a potential role of RAS dysregulation in AD-related neurodegeneration.

Paper Session

WHO BENEFITS, WHO BREAKS? MEASURING SURGICAL OUTCOMES IN OLDER ADULTS

Saturday, May 2

1:00 pm – 2:00 pm

P32

I CAN DO Surgical Advance Care Planning: Validation of Patient Nudges for a Multi-Site Randomized Controlled Trial

S. E. O'Brien,¹ L. Welton,³ R. L. Sudore,¹ C. Botsford,³ L. Pierce,¹ L. Gibbs,² J. C. Carmichael,² G. B. Melton,³ E. Wick.¹ 1. *UCSF, San Francisco, CA*; 2. *UCI, Irvine, CA*; 3. *UMN, Minneapolis, MN*.

Background: Advance care planning (ACP) helps patients clarify values and goals for future medical care. Scalable interventions to improve adoption of ACP are lacking, particularly for surgical patients. We hypothesize a preoperative patient portal message could prompt upload of new ACP documentation into the electronic health record (EHR).

Methods: Patients aged 65+ being evaluated for elective colorectal surgery in three healthcare systems were sent an ACP patient/caregiver co-developed letter and resources via the EHR portal. This methodology was adapted from a previous primary care pragmatic trial and tested over eight months.

Results: Overall, 639 patients were sent MyChart messages. Most patients spoke English (89%) with a median age of 73 years. Of message recipients, 17%(110) had prior advance directives (AD) and 2%(10) had prior physician-ordered life-sustaining treatment (POLST) forms in the EHR. During the study, 60 ACP documents were uploaded (44 ADs, 16 POLSTs), representing an absolute increase of 9%(19% to 28%) in ACP EHR documentation; a relative increase of 50%(Table 1). Notably, 89%(48) of study participants who uploaded forms had no record of prior ACP documentation in the EHR.

Conclusions: A single EHR portal message in the preoperative workflow successfully increased ACP documentation, particularly among previously unengaged patients. More robust interventions may be needed to drive holistic engagement in preoperative ACP. This study has informed a pragmatic randomized controlled trial at three healthcare systems evaluating the impact of message reminders and a healthcare navigator on ACP engagement.

Table 1: Metrics and ACP Engagement

Site Description	UCSF (Messages sent 2/21/24-10/21/24)	UCI (Messages sent 4/1/24-12/1/24)	Messages sent 2/21/24-10/21/24
Summary Metrics			
Total MyChart Letters Sent	214	293	132
% of Letters Opened by Recipients	186 (86.9%)	224 (76.5%)	105 (79.5%)
Time to Open (median, hours)	4.4	5.5	4.7
Demographics of Message Recipients			
Median Age	73	72	74
English-speaking	195 (91%)	245 (84%)	129 (98%)
Other	19 (9%)	48 (16%)	3 (2%)
Prior ACP Engagement of All Message Recipients			
% AD on file ever (prior to MyChart message)	41 (19%)	45 (15%)	24 (19%)
% POLST on file ever (prior to MyChart message)	3 (2%)	5 (2%)	0
New ACP Documentation			
New AD	13 (7%)	10 (3%)	19 (14%)
New POLST	7 (3%)	7 (2%)	2 (2%)

“Other” = Amharic, Cantonese, Mandarin, Toishanese, Farsi, French, Hindi, Indonesian, Japanese, Korean, Persian, Portuguese, Somali, Spanish, Tagalog, Russian, Urdu, Vietnamese

UCI= University of California, Irvine; UCSF= University of California, San Francisco; MHF= M Health Fairview

P33

The Impact of Obesity Severity on Short-Term Outcomes After Geriatric Hip Fracture Surgery: A NSQIP Database Analysis

A. O. Olawin, R. Saggat, J. Mullen, W. Austin, Z. Kuhn, G. Moloney, G. Russell. *Orthopedics, UPMC, Pittsburgh, PA.*

Background: Prior research has proposed a potential “obesity paradox,” suggesting obesity may improve survival after hip fracture. However, the impact of obesity severity on postoperative complications in older adults remains unclear. This study compares thirty-day complications across obesity classes in geriatric hip fracture patients and evaluates whether class III obesity increases complication risk. The goal is to provide clearer guidance for clinicians managing this vulnerable population.

Methods: We retrospectively reviewed the national surgical quality improvement program hip database to identify obese patients sixty-five years and older who underwent fixation for hip fracture from 2016 to 2023. Pathologic and atypical fractures were excluded. Obesity classes were defined as Class I (body mass index 30.0–34.9), Class II (35.0–39.9), and Class III (≥ 40.0). One-way analysis of variance with Tukey post hoc testing compared continuous variables. Chi-square tests with Bonferroni correction assessed associations between categorical variables and obesity class. Significance was set at $p < 0.05$ ($p < 0.0167$ for corrected comparisons).

Results: A total of 10,596 obese geriatric patients were included, with fracture types distributed as intertrochanteric ($n=5,968$), displaced femoral neck ($n=2,926$), subtrochanteric ($n=861$), and nondisplaced femoral neck ($n=841$). Mean body mass index was 34.4 ± 5.0 (7,376 Class I; 2,144 Class II; 1,076 Class III). Fracture type distribution did not differ across groups. Class III obesity was associated with longer operative times compared with Class I (14.68 minutes longer, $p < 0.001$). Reoperation within thirty days was higher in Class III than Class I (4.2% vs 2.5%, $p=0.002$). Class III also had higher rates of deep surgical site infection and pressure ulcers (0.6% vs 0.1%, $p < 0.001$; 6.4% vs 4.1%, $p < 0.01$). Cardiopulmonary complications were similar across classes (1.1% vs 1.0% vs 1.0%, $p=0.988$).

Conclusion: While fracture patterns do not differ by obesity class, class III obesity significantly increases the risk of early postoperative complications, including reoperation, deep infection, and pressure ulcers. These findings highlight the need for targeted risk counseling and perioperative optimization in this high-risk population.

P34 Student Presentation

Association Between Frailty and Complications in Medicare Beneficiaries Receiving Cataract Surgery

Y. Eichbaum,² M. Yu,¹ S. Gan,³ E. Whitlock,⁴ S. Ramanathan,⁴ N. Parikh,⁴ W. J. Boscardin,⁴ A. Huang,⁴ S. J. Lee,^{3,4} C. Chen.^{4,5}

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Background: Frailty is a clinical phenotype that has been associated with systemic complications in both high-risk and low-risk procedures. While cataract surgery is generally considered safe, patients undergoing cataract surgery are still at risk of developing ophthalmic or systemic complications due to their older age and multiple comorbidities. It is unknown whether frailty can be used to risk-stratify older adults undergoing cataract surgery.

Methods: In a cohort of Medicare beneficiaries from the 5% sample undergoing first-eye cataract surgery in 2017, we stratified patients by frailty quartiles using the previously validated Kim Claims-Based Frailty Index. We identified the proportion of patients within each frailty quartile who experienced systemic complications within 7 days or ophthalmic complications within 30 days after cataract surgery. We created two hierarchical multivariable models to determine the association between frailty and systemic or ophthalmic complications, respectively.

Results: We identified 36,652 cataract surgery patients with a mean age of 74.7 years; 59.2% were female, and 87.4% were White. We found that the proportion of patients experiencing systemic complications increased by frailty quartile (Q1 2.7%, Q2 5.5%, Q3 8.9%, and Q4 13.8%, respectively), whereas the proportion of patients experiencing ophthalmic complications was similar across all frailty quartiles (Q1 0.92%, Q2 0.88%, Q3 0.88%, and Q4 1.08%, respectively). Furthermore, we found an association between increasing frailty score and systemic complications. However, there was no association between frailty and ophthalmic complications.

Conclusions: The overall incidence of perioperative complications was low among Medicare beneficiaries undergoing cataract surgery. Increasing frailty score was associated with a higher risk of experiencing systemic complications, but not ophthalmic complications, after cataract surgery.

P35

Influence of Palliative Care Physician Participation in High-risk Surgery Board on Goals-of-Care Discussions

Y. Shichijo,¹ A. Samant,² M. Kaganovskaya,² G. Decastro,^{2,1} T. Heimann,^{2,1} A. Baim-Lance,^{1,2} F. Ko.^{1,2} 1. Icahn School of Medicine at Mount Sinai, New York, NY; 2. James J Peters VA Medical Center, Bronx, NY.

Background:

Multidisciplinary high-risk surgery consultation enables preoperative risk stratification and mitigation to improve surgical outcomes. This consultation prioritizes preoperative medical optimization rather than value-goal-care alignment key to the patient-centered care of vulnerable individuals. We examined whether inclusion of a board-certified palliative care physician in a high-risk Quality Surgery Board (QSB) enhances preoperative multidisciplinary discussion of patient goals in frail older adults.

Methods:

Veterans who were frail (Risk Analysis Index > 37) referred for preoperative QSB e-consultation at a Veterans Affairs Hospital in New York (Feb 2023–Jan 2025) were included. QSB membership was expanded in Feb 2024 to include a board-certified palliative care physician. QSB cases discussed before ($n=163$) and after ($n=170$) the addition of palliative care expertise were compared. Outcomes included frequencies and triggers of preoperative goals of care (GOC) discussions.

Results:

Among the 333 cases reviewed, the mean age was 73.8 ± 9.0 years, 97.9% were male, 48% were White, 40.5% were Black, and 15.3% were Latino. The inclusion of palliative care representation in QSB was associated with a higher rate of recommendation for preoperative GOC discussions (19 cases, 11.1% vs 8 cases, 4.9%; $p < 0.05$, chi-square). In cases discussed after the addition of palliative care, triggers for GOC discussions included potential misalignment between surgical intervention and patient goals (68%), high-risk status due to multimorbidity (53%), dementia or severe frailty (26%), anticipated airway challenges (21%), and anticipated decline in quality of life (5%).

Conclusion:

This study provides preliminary evidence suggesting that embedding palliative care expertise within a multidisciplinary surgery board enables identification of frail, high-risk patients in whom surgical intervention may not be aligned with their values, and thus creates an added opportunity for the clinical team to deliver patient-centered, goal-concordant care. Additional research is needed to identify the optimal upstream communication approach to support meaningful preoperative goals of care discussions in these vulnerable individuals.

Paper Session

HEALTH SERVICES & POLICY RESEARCH

Saturday, May 2
2:15 pm – 3:15 pm

P36

Using a Standardized EHR Note to Identify Characteristics of Patients Reported for Elder Abuse and Self-Neglect in a National Health System

L. K. Makaroun,^{1,2} L. Kao,^{2,1} H. Zhang,¹ M. K. Mor,^{1,2} T. Rosen,³ C. T. Thorpe.^{1,4} 1. VA Pittsburgh Healthcare System, Pittsburgh, PA; 2. University of Pittsburgh, Pittsburgh, PA; 3. Weill Cornell Medical College/New-York Presbyterian Hospital, New York, NY; 4. University of North Carolina, Chapel Hill, NC.

Background: Each year, 10% of older adults experience elder abuse (EA) and up to 30% may experience self-neglect (SN), with myriad health consequences. While healthcare systems play a critical role in EA/SN identification and response, there has been a lack of standardized data on patients experiencing EA/SN to guide intervention programs. The Veterans Health Administration (VHA) recently piloted then nationally implemented an electronic health record (EHR) note template to document reports of suspected abuse/neglect with standardized structured data elements, providing a unique opportunity to study EA/SN in a national population.

Methods: Using data from the note, we identified veterans aged ≥ 60 years reported for EA/SN in VHA during the 10-site pilot (3/2024 – 2/2025) and first three months of national implementation (3/2025 – 5/2025) of the EHR template. Using VHA medical record data, we described baseline veteran clinical and sociodemographic characteristics, EA/SN case details and post-reporting social work encounters.

Results: In total, 1,982 EA/SN reports were made for 1,684 unique veterans. Reports were most frequently for self-neglect (36%), financial exploitation (18%) and multiple abuse types (24%). Reported veterans had median age 76 years, were 93% male, 20% non-Hispanic Black and 4% Hispanic, with 30% married. Thirty-three percent lived in rural/highly rural areas. Among EA cases ($N=1,253$), suspected harmers were most often adult children (19%) or multiple individuals (24%). Overall, veterans with EA/SN reports had a high prevalence of function-related and mental health conditions, including frailty (67%), dementia (54%), hearing loss (22%), alcohol use disorder (17%),

depression (24%) and PTSD (22%). Including the date of the report, 79% of all reports were followed within 90 days by an encounter with a VA social worker.

Conclusions: Using novel data from a new standardized VHA EHR abuse/neglect reporting note, we found that veterans experiencing EA/SN frequently had functional and cognitive impairment and often experienced multiple forms of abuse. Future research leveraging these data may provide actionable insights to inform targeted clinical and preventive interventions.

P37

Real-World Use of Lecanemab Among US Adults with Alzheimer's Disease

R. Gupta,^{1,2} M. Kim,² D. Polsky,² J. B. Segal,^{1,2} E. Oh,² K. S. Thomas,² S. Singh,³ G. C. Alexander,^{1,2} J. F. Levy.²

1. Johns Hopkins University School of Medicine, Baltimore, MD;

2. Johns Hopkins Bloomberg School of Public Health, Baltimore, MD;

3. UMass Chan Medical School, Worcester, MA.

Background: Lecanemab (Leqembi) is a monoclonal antibody approved by the U.S. Food and Drug Administration for the treatment of Alzheimer's disease. In clinical trials, biweekly infusions modestly slow cognitive decline, while requiring frequent MRI monitoring to assess for amyloid-related imaging abnormalities (ARIA) including cerebral edema and microhemorrhage. Little is known about the factors associated with real-world lecanemab adoption and adherence.

Methods: We used Truveta, a large, diverse, national electronic health record repository linked to claims data (30 contributing health systems), to identify patients prescribed and initiating lecanemab between May 2023 and August 2025. We described sociodemographic and clinical characteristics associated with early discontinuation among patients initiating lecanemab. Using the first lecanemab administration as the index date, we applied Kaplan-Meier methods to estimate time to discontinuation (defined as ≥ 60 days from the last expected treatment), censoring for death, disenrollment, or study end.

Results: We identified 476 patients initiating lecanemab. Lecanemab initiators in our sample had a median age of 74 (69-78) years; 55.7% of initiators were female, 87.4% white, 2.9% black, 2.7% Hispanic, and 62.6% were urban dwellers. Among initiators, 7% had a diagnosis of mild cognitive impairment, 80% had a diagnosis of dementia, and 51% had reported APOE4 testing. Anticoagulant and antiplatelet use was infrequent. Among lecanemab initiators, 142 (30%) discontinued treatment with a median time to discontinuation of 130 days (IQR, 101-190). In unadjusted analyses, demographic characteristics were similar between discontinuers and continuers. Use of concurrent older dementia medications was common, with small differences between discontinuers and continuers. Discontinuers had fewer comorbidities (median [IQR] Charlson Comorbidity Index, 1 [1-4] vs 3 [1-4]; $p < 0.001$).

Conclusion: Using real-world data, we found that a substantial share of patients initiating lecanemab discontinued treatment early, though there were few demographic or clinical differences between patients who discontinued and those who continued therapy. Further investigation of the underlying drivers of early discontinuation is needed.

P38 Student Presentation

Practice Patterns among Primary Care Clinicians Caring for People Living with Dementia: Evidence from the National Dementia Workforce Study

J. Tian, A. Alsharawy, M. Hu, A. D. Naik, Y. Hou. School of Public Health, UTHealth Houston, Houston, TX.

Background: The majority of people living with dementia (PLWD) receive care from primary care clinicians (primary care physicians [PCP], nurse practitioners [NP], and physician assistants

[PA]). Yet little is known about variations in their dementia-related practice patterns and implications for care quality. This study aimed to characterize distinct practice pattern types among primary care clinicians caring for PLWD through a clustering analysis.

Methods: We included 2,501 primary care clinicians (46.2% PCPs; 39.0% NPs; 14.8% PAs) from the National Dementia Workforce Study Wave 1 public use file. We used k-means clustering to derive practice pattern clusters based on self-reported practice patterns related to provision of cognitive assessment, diagnostic testing, clinical care management, and support services. We examined the share of clinicians within each derived cluster who reported sometimes or routinely providing or referring patients to each service, combined with clinical judgement. Survey weights were applied to provide nationally representative estimates; missing data were handled using multiple imputation.

Results: Clustering analysis and clinical interpretation revealed four distinct practice pattern types among clinicians: high-intensity (n=491), coordination-oriented (n=750), traditional (n=939), and low-engagement (n=321). High-intensity clinicians reported significantly higher use of, or referral to, advanced diagnostic testing (e.g., cerebrospinal fluid biomarker testing [39.2%]) and provision of anti-amyloid therapies (47.3%) than clinicians in other clusters. While both coordination-oriented and traditional clinicians relied on conventional diagnostic tests and clinical care management, coordination-oriented clinicians provided substantially more support services (driver evaluation [78.6%] and elder abuse resources [93.5%]) than traditional clinicians (43.2% and 53.1%). Low-engagement clinicians, with a higher proportion of NPs and PAs, reported consistently minimal provision across all measures.

Conclusions: These typologies add to our understanding of variation in practice patterns among primary care clinicians caring for PLWD. Future directions include examining how patient, clinician, and practice environment influence practice pattern types and implications for dementia care utilization, costs, and patient outcomes.

P39

Health care contact days among older adults after emergency department visits: a cross-sectional analysis

C. Gettel,¹ C. Rothenberg,¹ C. Kitchen,¹ Y. Song,¹ S. N. Hastings,² U. Hwang,³ M. Fischer,⁴ C. Shenvi,⁵ A. Venkatesh.¹ 1. *Emergency Medicine, Yale School of Medicine, Woodbridge, CT*; 2. *Internal Medicine, Duke University School of Medicine, Durham, NC*; 3. *Emergency Medicine, New York University Grossman School of Medicine, New York, NY*; 4. *Emergency Medicine, Penn State Health Milton S. Hershey Medical Center, Hershey, PA*; 5. *Emergency Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC*.

Background: Emergency department (ED) visits among older adults represent critical transition points in health care, often resulting in substantial downstream utilization. We aimed to quantify health care contact days in the 30 days following a treat-and-release ED visit among older adults and examine associations with demographic and clinical characteristics.

Methods: We conducted a pooled cross-sectional analysis of 2016-2021 Medicare Current Beneficiary Survey data. The sample included treat-and-release ED visits among beneficiaries ≥ 65 years. Health care contact days were categorized as **institutional** (ED, hospital, skilled nursing facility, hospice) and **ambulatory** (outpatient visits, labs, imaging, procedures, or treatments). We applied zero-inflated Poisson regression to estimate the likelihood and intensity of health care contact.

Results: The analytic sample comprised 10,964 treat-and-release ED visits. Within 30 days, 22.5% of visits resulted in institutional contact and 84.4% in ambulatory contact. On average, each ED visit was followed by 4.3 total contact days (3.0 ambulatory, 1.3 institutional) within 30 days. Having ≥ 2 chronic conditions was associated

with greater odds of both institutional (OR 1.46, 95% CI 1.28–1.66) and ambulatory contact (OR 1.44, 95% CI 1.25–1.66). Dementia was associated with reduced odds of ambulatory contact (OR 0.51, 95% CI 0.37–0.72).

Conclusions: Older adults experience frequent and sustained health care contact following treat-and-release ED visits, with particularly high intensity among those with multi-morbidity. Reduced ambulatory follow-up among patients with dementia highlights a potential gap in care coordination after ED discharge.

POSTER SESSION A

Wednesday, April 29

7:00 pm – 8:00 pm

A1

Association of Cognitive Impairment with Caregiver Burden

A. Chang, D. Carr, M. E. Rau. *Geriatrics, Washington University in St. Louis, St Louis, MO*.

Background: An estimated 15-20% of adults in the U.S. are caring for a family member and are at risk for caregiver burden. The association between cognitive decline and caregiver burden is well-established in the literature. Caregivers have been observed to show generalized decline in episodic memory, working memory, and executive function. Additionally, neuropsychiatric symptoms of agitation, apathy, disinhibition, irritability, and sleep disorders are strongly associated with caregiver burden.

Case summary: An 83 yo woman was evaluated at the Memory Diagnostics clinic for worsening memory and behavior. She is the primary caregiver for her husband who has worsening dementia. The collateral source (CS) notes the patient's husband has had multiple ED visits and hospitalizations, which increased the caregiver burden on the patient. The CS noted significant decline in memory, personality and behavior in the patient, specifically increased difficulty with language comprehension. She was noted to be more irritable and agitated as well as requiring additional help with IADLs. Psychometric testing scores included MMSE (28/30 to 25/30) and TMTA (22 secs to 49 secs). Her depression and lab evaluations were unrevealing. MRI brain with volumetrics showed no significant qualitative or quantitative brain volume loss though did show chronic microvascular changes. Evaluation was consistent with mild cognitive impairment due to caregiver burden. Recommendations included hiring additional help to offload the caregiver burden. Upon follow up, the CS reported improvement in patient's cognition and behavior with less caregiver burden.

Discussion: Our patient showed a decline in language comprehension and executive function but also increased functional impairment and behavioral disturbance as her caregiver burden increased. As her caregiver burden decreased, there were improvements in her cognition, behavior, and personality. This case supports data showing dementia caregivers appearing more particularly vulnerable to cognitive decline. Interventions to relieve stress are critical for caregivers experiencing symptoms of cognitive decline and behavior. Longitudinal follow up is important to determine whether these symptoms are reversible when the stress is alleviated or if they are a harbinger of a neurodegenerative disease.

A2

When Compassion Means Taking the Lead: Using Palliative Paternalism to Ease Family Trauma in End-of-Life Decisions

A. Fryd,¹ M. Fitzpatrick,¹ A. Tangella,² A. Suresh,¹ E. Haile,³ T. Wyand,¹ M. Ruhi.⁴ 1. *MedStar Georgetown University Hospital, Washington, DC*; 2. *MedStar Washington Hospital Center, Washington, DC*; 3. *Walter Reed Medical Center, Bethesda, MD*; 4. *Veterans Affairs Medical Center, Washington, DC*.

Background

Families of critically ill patients often struggle long after the ICU stay ends. Many describe reliving the moment they were asked to decide about life support, wondering if they made the “right” choice. Research shows that post-traumatic stress is common in these situations—especially when families believe their decision caused their loved one’s death. Physicians often wrestle with how much to say about a poor prognosis, fearing they might be wrong or take away hope. Yet when communication is delayed or avoided, families are left to make impossible choices on their own—decisions that can weigh on them for years.

Studies suggest delaying tracheostomy until at least 14 days when prognosis is excellent, but the same reasoning may apply—perhaps more strongly—when the outlook is extremely poor. Allowing time for families to process emotions, rather than rushing into tracheostomy or extubation decisions, may reduce trauma and foster acceptance.

Methods/Results

We describe two ICU patients with severe anoxic brain injury after cardiac arrest. Multiple teams—pulmonary, neurology, oncology, and nephrology—were uncertain about prognosis and avoided direct conversations. Early geriatric and palliative team involvement allowed rapport-building, regular meetings, and gradual reframing from “options” to “what the illness has already decided”. Through this approach, we used a compassionate form of palliative paternalism, offering clear recommendations rather than open-ended choices.

Both patients died peacefully—one in the ICU under comfort care, the other in inpatient hospice within 48 hours. In both cases, families expressed relief that the team had guided the process, sparing them the burden of “choosing death.”

Conclusions

Families should not carry the full weight of end-of-life decisions alone. When physicians lead prognosis discussions early and with empathy, families find peace rather than guilt. Taking ownership of these conversations restores trust, offers comfort, and allows dying to be understood as an act of care and love.

A3

A Case of Occult Thoracic Epidural Abscess in a Patient with Chronic Back Pain, Delirium, and Urinary Retention

A. Stucky. *Maine Dartmouth Family Medicine Residency, Augusta, ME*.

Background: Spinal epidural abscess (SEA) requires prompt recognition and intervention to prevent severe complications and fatalities. The incidence of SEA is rare, although increasing, and higher among individuals with diabetes, intravenous drug use, or a history of invasive spinal procedures. SEA manifests with various symptoms, predominantly back pain, fever, and neurological deficits. Recognizing these common signs is crucial for early intervention which improves patient outcomes.

The Case: The patient is a 73-year-old male, with chronic back pain who was admitted to the hospital with altered mental status resulting in a fall at home. He received treatment for diabetic ketoacidosis and was diagnosed with a L1 vertebral compression fracture. The prolonged stay was complicated by bacteremia secondary to osteomyelitis of the right 3rd toe, delirium and recurrent catheter associated urinary tract infection (CAUTI). Due to ongoing delirium and confusion, he was discharged to a memory care skilled nursing facility (SNF) for subacute rehabilitation. The patient had a history

of misuse of prescribed opioids and although multiple regimens of narcotic medication were tried, he frequently declined therapy due to pain. He also required replacement of an indwelling urinary catheter due to urinary retention and was treated for urinary infection while at the SNF. His mentation improved and he was transferred to a long-term care facility where he was noted to have worsening pain and weakness of his lower extremities. Imaging revealed multifocal spinal osteomyelitis with thoracic level epidural abscesses. He underwent T6 and T10 laminectomies and was treated with six weeks of IV antibiotics with significant improvement in pain.

Conclusion: Diagnosing an epidural abscess can be challenging in a patient with chronic back pain particularly with the additional history of urinary retention and delirium as these illnesses may mask the typical presenting symptoms for SEA. This case demonstrates the difficulty in assessing a patient with cognitive impairment with a history of poorly controlled chronic pain. Physicians should be mindful that persistent and worsening symptoms may indicate a new disease process or infection.

A4

Bridging the gap – the impact of housing instability on medical care

A. Wang,^{1,2} C. Kuwata,^{1,2} C. Yamashita.^{1,2} 1. *Keck School of Medicine of the University of Southern California, Los Angeles, CA*; 2. *LA General Medical Center, LA, CA*.

Background

Medical respite is a model of care intended to provide health care, financial, and housing resources to patient experiencing housing insecurity or homelessness. This case highlights a patient’s journey and clinical outcomes through housing insecurity and different types of medical respite care.

Methods

We present a case study investigation of the patient’s clinical history, care utilization, and correlation to different levels of housing and medical respite care.

Results

This patient is an 81-year-old man with uncontrolled type 2 diabetes mellitus, chronic kidney disease, chronic right sided hemiballismus who has routinely followed with a safety-net geriatrics patient-centered medical home over the last several years. Numerous changes in his housing stability have occurred over the years with transitions between living in an apartment, experiencing housing insecurity, becoming homeless, and finding placement in different types of medical respite care.

As his housing status changed, there was an associated change in ability to have consistent outpatient follow-up as noted by increasing missed appointments while transitioning from respite care to local shelter housing. While living at the shelter, this patient reported having his medications stolen multiple times, as well as difficulty accessing carbohydrate consistent meals for his diabetes management. His lab work reflects these challenges with consistent medical care, with worsening of chronic anemia, worsening diabetes, and malnutrition.

Conclusion

This patient’s complicated housing history and the correlating trends in his outpatient provider visits suggests an underlying relationship between housing insecurity, transitions in housing, and ability to access routine care. His history additionally reflects the effects of transitions of care on his access to housing and food resources, in addition to the impact on his chronic medical conditions. The increased vulnerability of our older population requires thoughtful implementation of integrative models of healthcare that appropriately addresses this intersection of complicated social determinants of health and management of chronic disease and acute illness.

A5

Hidden Bleeding Risk: SSRI-Associated Ecchymosis in an Older Adult

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Introduction: Easy bruising in older adults is frequently attributed to age-related vascular fragility, trauma, or anticoagulant use. However, selective serotonin reuptake inhibitors (SSRIs) are associated with a 12–64% increased risk of bleeding¹. The mechanism is thought to involve inhibition of serotonin-mediated platelet activation, leading to platelet dysfunction. Approximately 1 in 5 older adults uses an antidepressant, with SSRIs being the most prescribed class². Awareness of this association is essential when evaluating unexplained bruising in geriatric patients.

Case presentation: A 77-year-old male with anxiety, depression, hypertension, diabetes, and benign prostatic hyperplasia presented with easy bruising of the bilateral arms and bleeding from minor skin breaks for several weeks. He reported that symptoms sometimes occurred without major trauma or clear injury. His current medications included sertraline, metoprolol, tamsulosin, valsartan, amlodipine, metformin, and rosuvastatin. He was not taking an anticoagulant or antiplatelet agent. Physical exam revealed scattered bilateral arm ecchymoses. Laboratory data were unremarkable. A careful medication review showed that his bruising had begun after the initiation of sertraline for anxiety and depression. Through shared decision-making, sertraline was continued due to its positive impact on his mood symptoms, and the patient was counseled that a non-SSRI antidepressant could be used if symptoms of bruising and bleeding became more bothersome. He expressed relief in understanding the possible medication association.

Discussion: Bleeding abnormalities associated with SSRIs are under-recognized in geriatric care. Age-related dermal thinning, vascular fragility, and frequent polypharmacy—including the common use of antithrombotic agents—further heighten vulnerability. This case highlights the need to consider SSRIs as a cause of new bruising or bleeding in older adults, particularly when symptoms develop after initiation of this drug class. It also underscores the need for thorough medication reconciliation, bleeding-risk identification, and patient education about potential bruising and bleeding prior to SSRI initiation in this population.

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A6

Engaging African American Faith Communities in Dementia Education and Research Participation: Lessons from a Brain Care Ministry

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Background:

Faith-based communities are trusted sources of health information in African American communities. They support older adults through trusted relationships and culturally relevant communication strategies. This case describes the development of a Brain Care Ministry at a mid-sized church in central Virginia.

Methods:

Church leaders partnered with Alter; an organization focused on dementia awareness in African American faith communities. With Alter's support, the church developed a ministry dedicated to dementia awareness, caregiver support, and brain health. The ministry's initial programming included Purple Sundays, an initiative by the Alzheimer's Association to raise awareness about dementia.

Results:

Since launching in 2024, the church has hosted three Purple Sundays, participated in a community fair, and hosted dementia education seminars. Over 400 people participated across the multiple events. In addition, the implemented educational sessions were designed to increase awareness of dementia subtypes and to advance knowledge of the Six Pillars of Brain Health, using didactic and discussion-based formats to encourage practical application. Early observations indicate that congregants were willing to discuss memory concerns in a faith-based setting and that caregivers are open to sharing their experiences.

Additionally, dementia messaging presented through the Brain Care Ministry led to tangible results. When researchers attended the community fair and the educational session on brain health and shared details about their clinical study, several church attendees enrolled (n=24).

Conclusions:

The ministry has identified future opportunities for caregiver support groups and programming that teach youth about dementia. This case demonstrates the feasibility and acceptability of a church-based brain health initiative and highlights faith communities as trusted partners in dementia education and research efforts.

A7

Three Years, Many Opinions: A Deprescribing Journey in an Older Adult

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Adverse drug events (ADE) can occur at any age, and emerging literature highlights the potential for unusual side effects in older adults, potentially related to impaired metabolism or age-related physiologic changes. Geriatrics practices are uniquely positioned to diagnose these potential ADE due to the collaborative environment and training focused on deprescribing.

Case Presentation: 88-year-old non-English speaking woman with hypertension and hyperlipidemia presented with a three-year history of intermittent, diffuse warmth, and burning sensation. No diaphoresis, excoriations, rash and no aggravating factors. Prior the Geriatrics consultation, she had evaluations with her PCP, neurologist, allergist, and dermatologist, which were unrevealing. She had trialed multiple medications—gabapentin, pregabalin, amitriptyline, hydroxyzine, fexofenadine, and montelukast—with limited to no benefit; amitriptyline provided some relief but was discontinued due to ADE. She tried a first-generation oral antihistamine, Fenistil (unavailable in the USA), and noted moderate but transient symptom improvement. Medication reconciliation completed by the clinical pharmacist noted only Losartan 50 mg daily for the past 10 years. This was discontinued. Patient noted gradual resolution of symptoms, with discontinuation of Fenistil 2 weeks later.

Discussion: Medication reconciliation is an essential part of geriatric assessment and can prevent prescribing cascades. To our knowledge, burning sensations have not been reported in clinical trials or postmarketing data for losartan, making this potentially the first documented case. The patient's symptoms may have resulted from ARB-related RAAS blockade shifting toward angiotensin receptor activation, causing mild vasodilation perceived as warmth or flushing. This case underscores that ADE in older adults can present differently than in younger patients, and this may have been an idiosyncratic reaction occurring in this patient.

Conclusion: Simple interventions can often resolve complex, nonspecific symptoms in older adults and demonstrate the value of interprofessional geriatric assessments. The intervention that ultimately resolved the patient's symptoms was straightforward but overlooked by numerous other providers—deprescribing a long-standing medication.

A8

Frontotemporal Dementia Complicated by Substance Use, Depression and Personality Disorder

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Background:

Frontotemporal dementia (FTD) is a leading cause of early-onset neurodegeneration, presenting with progressive behavioral and language changes. It shares features with other dementia etiologies, mood and movement disorders, often delaying diagnosis. We present a case of an older female, with complex personality changes presenting to our office for further management of these complex symptoms.

Methods:

This is the case of an 83-year-old woman presenting to the geriatric clinic to establish care. PMH chronic insomnia, anxiety, depression, hypertension, hypothyroidism, hyperparathyroidism, parathyroidectomy, gastric bypass, sciatica, osteoporosis, restless leg syndrome, hyperlipidemia, and obstructive sleep apnea. The family of the patient reported several years of progressive cognitive decline and worsening alcohol use during the COVID-19 pandemic. Medication review found multiple OTC agents and expired and active prescription meds, including benzodiazepines, antidepressants and hypnotics. Initial visits focused on BEERS-guided deprescribing. Due to her complex history and medication use, she was referred to both psychiatry and neurology. While the patient tested very well with neuropsychiatric testing, the patient clinically continued to have loss of IADL's, such as difficulties with hygiene and dressing, in addition to short-term memory loss. Given these discrepancies and that the concern for dementia was not fully defined, the team decided to pursue evaluation with MRI and PET imaging. As a result, imaging demonstrated findings consistent with frontotemporal dementia, with possible mixed features of dementia given mild hypometabolism in the precuneus and posterior cingulate gyri.

Conclusions:

This case highlights multiple factors involved in evaluating behavioral changes in older adults and the diagnostic challenges created by overlapping mood, cognitive, and functional symptoms. Frontotemporal dementia is particularly difficult to diagnose due to its heterogeneous presentation and its frequent overlap with psychiatric conditions and other dementias. Despite these complexities, a structured, comprehensive approach can help clinicians arrive at an accurate diagnosis. This case also underscores the critical role of the interdisciplinary team in recognizing and managing complex dementia presentations in geriatric care.

A9

Mirtazapine-Induced Visual Hallucination in Older Adult. Recognizing a Rare but Important Adverse Effects Amidst Mixed Evidence

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Introduction: A limited number of anecdotal case reports have noted alleviation of visual and auditory hallucinations with mirtazapine use, especially among individuals with Parkinson's disease. Although mirtazapine is typically well tolerated, visual hallucinations have been rarely reported as a potential adverse effect. This case adds to the limited literature describing mirtazapine-induced hallucinations and its complete resolution following discontinuation of therapy.

Case Presentation: A 96-year-old robust, community dwelling, cognitively intact male with history of depression and recent treatment for throat cancer status post surgery and radiation presented with poor appetite and unintentional weight loss. Due to overlapping symptoms, he was initiated on low-dose Mirtazapine 7.5 mg. At follow up, his appetite, sleep and mood had improved. However, he reported new

bilateral visual hallucinations. He described seeing his wife step out of a picture, with no other visual or auditory hallucinations reported. We suspected mirtazapine as the cause of his visual hallucinations, given their onset shortly after the medication was initiated. The medication was discontinued, after which the hallucinations were resolved immediately. Mirtazapine was subsequently added to his drug allergy list.

Discussion:

This case highlights that mirtazapine can rarely cause visual hallucinations, even at low doses. Notably, these symptoms may develop after several months of therapy rather than only at treatment initiation. Physicians should maintain a low threshold of suspicion for medication-induced hallucinations in older adults, as early recognition can prevent unnecessary diagnostic evaluations and interventions for other potential causes.

Conclusion: Further research is needed to understand the pathophysiology of this rare adverse effect of mirtazapine-induced hallucinations and to resolve inconsistencies in the existing literature. The timing and onset of this reaction also warrant additional study.

A10

Who would have thought that Rheumatoid Arthritis can lead a 46 year old to live in long term care

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Background

Patients not currently treated with advanced therapies experience profound difficulties in everyday living with RA, across a range of measures. Among adults with arthritis in the United States, anxiety and depression are twice as common compared to among the general population

Case

46 yo AA female was admitted to a local hospital for 5 weeks in Spring 2025 for pain and severe debility because of seropositive erosive RA. It was diagnosed 2016, in the past on Methotrexate, Plaquenil, Humira and Enbrel with partial response. Patient moved to another state in 2019 and lost to follow up and stopped all medications. She declined from severe pain, stiffness and concomitant depression to the point of being bed bound and developing decubiti. Her teenaged children would turn her, feed her and perform continence care. She lost 100 lbs. Reportedly in the hospital in NC for 2 months, where her decubiti healed but she was still extremely weak. They couldn't find a rehab so her family brought her to PA straight to the hospital.

She was malnourished and needed to be placed back on her RA meds, including MTX and Prednisone. She started on Cymbalta for depression. In the hospital, she could not even roll over and at the time of discharge she was able to transfer with 2 heavy assist.

Labs:

Rheumatoid factor 27, CCP more than 340

SSA antibody 145

Meds

Cyanocobalamin 1000mg

FeSO4 325 mg qod

Mag Ox 400 mg bid

Thiamine 100 mg daily

Prednisone 10mg daily

Methotrexate 12.5mg weekly

Folic acid 2 mg

Lovenox 40mg sq daily

Duloxetine 30 mg daily

Cyclobenzaprine 5mg TID PRN

Oxycodone 5mg q 4 PRN

Course:

Arrived to our SNF in late May 2025. Was able to stand for 30 seconds that first week and could not even pull up pants. Slowly progressed to walking 60 feet and managing toileting. Gained weight. It took some time to re-establish and reconnect with

community rheumatologist. MXT increased and finally got approval for Tocilizumab-aazg in October 2025. Family needs extra time to make home livable and WC friendly hence patient had to apply for medical assistance and transition to LTC.

A11

Asymptomatic Primary Hyperparathyroidism Revealing Parathyroid Adenoma: A Case Report

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Background: Primary hyperparathyroidism is most often caused by a parathyroid adenoma and is frequently discovered incidentally when laboratory studies show hypercalcemia with an inappropriately normal or elevated parathyroid hormone PTH level. Older adults may present with subtle or nonspecific symptoms, and asymptomatic disease is increasingly common, requiring careful interpretation of calcium and PTH values. This challenge was exemplified by a 76 year old woman with multiple chronic conditions who presented for routine follow up and was found to have rising serum calcium without classic symptoms such as nephrolithiasis or bone pain. Her calcium increased to 11.7 mg/dL over one year while her PTH remained within the reference range. Hydrochlorothiazide was sto a physiologically inappropriate finding that prompted further evaluation despite initially negative imaging.

Methods: Clinical presentation, laboratory results, diagnostic imaging, and treatment decisions were reviewed, hydrochlorothiazide was discontinued. Workup included serum calcium and PTH levels, nuclear parathyroid scan, thyroid ultrasound, CT imaging, and bronchoscopy with biopsy to evaluate possible malignancy.

Results: Initial nuclear parathyroid scanning was negative. However, routine cancer screening revealed a 2.2 cm spiculated right lower lobe lung nodule. Oncology referral led to a thyroid ultrasound identifying a suspicious right superior parathyroid lesion measuring $7.7 \times 5.6 \times 8.4$ mm. A dedicated CT parathyroid scan confirmed the presence of an adenoma. ENT evaluation resulted in a right parathyroidectomy. Bronchoscopy with transbronchial biopsy of the lung nodule revealed no evidence of malignancy. Postoperatively, the patient's serum calcium began trending downward, consistent with biochemical cure. She will continue long term monitoring with serial calcium and PTH levels.

Conclusions: This case illustrates the importance of recognizing inappropriately normal PTH values in older adults with hypercalcemia. Negative initial imaging should not deter additional evaluation when biochemical findings are discordant. Although malignancy was excluded in this patient, it remains a critical part of the differential diagnosis in hypercalcemia. Early recognition and timely intervention in primary hyperparathyroidism can prevent complications and improve outcomes in geriatric patients.

A12

Late-Onset Myasthenia Gravis Presenting with Bulbar and Respiratory Symptoms in an 82-Year-Old Woman

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Background:

Myasthenia gravis (MG) is increasingly recognized in older adults, yet diagnosis may be delayed because symptoms overlap with stroke, delirium, or age-related ptosis. Older adults often present with bulbar and respiratory involvement, and timely recognition is essential to prevent myasthenic crisis.

Case Presentation:

An 82-year-old woman presented with six days of worsening diplopia, dysphagia, cough, and shortness of breath. She reported increasing difficulty swallowing with frequent choking episodes. On arrival, the patient was hypoxic to 88 percent, tachycardic, and

tachypneic. Imaging of the head and chest was normal. Neurology was consulted for possible stroke versus neuromuscular disease. Examination revealed bilateral ptosis and fatigable weakness. The ice-pack test improved ptosis, and antibody testing confirmed the presence of acetylcholine receptor antibodies. Respiratory measures showed significantly reduced negative inspiratory force and vital capacity, requiring close monitoring for evolving myasthenic crisis.

Results:

The patient was diagnosed with late-onset MG with advanced bulbar and respiratory involvement. She received pyridostigmine, immunomodulatory therapy, and supportive care. Despite treatment, her respiratory status continued to decline, and she experienced persistent dysphagia with high aspiration risk. After discussions with her care team and family, she elected for comfort-focused care and transitioned to hospice.

Discussion:

MG in older adults can present atypically and often mimics stroke or aspiration-related illness. Late-onset MG frequently involves bulbar dysfunction and respiratory compromise. Bedside testing, including the ice-pack test, provides rapid diagnostic support, and antibody testing confirms most cases. Treatment considerations must account for frailty, comorbidities, and tolerance of immunotherapy. For patients with advanced disease or limited response to treatment, goals-of-care discussions are essential.

Conclusion:

This case highlights the importance of considering MG in older adults presenting with acute bulbar or respiratory symptoms. Early recognition, timely diagnostic testing, vigilant respiratory monitoring, and thoughtful goals-of-care planning are essential. Hospice may be appropriate when the disease progresses despite optimal treatment.

A13

Pharyngeal Involvement in Oropharyngeal Candidiasis: Case Report Highlighting Diagnostic Challenges and Implications of Odynophagia & Decreased Intake

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Oropharyngeal candidiasis is a common opportunistic infection, particularly in immunocompromised and debilitated patients. While oral involvement is frequently recognized and treated, pharyngeal extension may be underappreciated, especially when clinical assessment is limited to the oral cavity. Nystatin suspension is often used as first-line therapy for mild oral candidiasis; however, its efficacy is limited in cases with significant pharyngeal involvement due to suboptimal mucosal contact and poor penetration beyond the oral cavity. Failure to identify and adequately treat pharyngeal candidiasis can result in persistent symptoms, including odynophagia, dysphagia, poor oral intake, and, in vulnerable populations, may contribute to nutritional compromise and failure to thrive.

A 73-year-old female with a medical history significant for hypertension, type 2 diabetes mellitus, nonalcoholic steatohepatitis, and obstructive sleep apnea presented to an outside hospital with worsening abdominal pain. She had a known pelvic mass, and a CT scan revealed a large, 17 cm complex cystic pelvic mass concerning for ovarian neoplasm, associated with hydronephrosis. Bilateral nephrostomy tubes were placed, resulting in improvement of her renal function as evidenced by a downtrend in creatinine. Her hospital course was complicated by acute hypoxic respiratory failure secondary to an acute pulmonary embolism. During her admission, she developed persistent chest pain that was exacerbated by oral intake. She reported odynophagia and was unable to tolerate oral intake due to pain with swallowing. Examination and clinical suspicion were consistent with oropharyngeal and esophageal candidiasis. She was initially treated with multiple courses of nystatin oral suspension without clinical improvement. Given persistent symptoms, her antifungal therapy was

escalated to intravenous fluconazole, which led to significant improvement in her esophageal and chest pain, as well as her ability to tolerate oral intake. This case highlights the importance of considering esophageal candidiasis in immunocompromised or chronically ill patients with odynophagia and chest pain, and the need to escalate antifungal therapy when topical agents fail. This also emphasizes the importance of considering all possible etiologies of decreased PO intake before considering appetite stimulation and alternative methods of nutrition.

A14

Severe Nausea-Induced Vasovagal Syncope in an 87-Year-Old Female: Resolution with Scheduled Ondansetron

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Background: Vasovagal syncope (VVS) is a common cause of transient loss of consciousness in older adults and may be triggered by autonomic responses to pain, emotional stress, or gastrointestinal stimuli. Although typically benign, recurrent episodes can lead to falls, and functional decline. Early detection of reversible triggers, including nausea and constipation, is essential.

Case Description: An 87-year-old woman with hypertension, gastroesophageal reflux disease, and osteoarthritis presented with recurrent dizziness and syncope that progressed from monthly to several times per week over one year. Episodes occurred mainly in the morning after taking amlodipine with coffee on an empty stomach and were accompanied by severe nausea, vomiting, weakness, and cold extremities, without chest pain or dyspnea. Emergency evaluations ruled out infection, pulmonary embolism, acute coronary syndrome, intracranial pathology, and cerebrovascular accident. Blood pressure during episodes was elevated, and orthostatic vitals were normal. Cardiology workup showed mild diastolic dysfunction, mild aortic insufficiency, and occasional supraventricular tachycardia not associated with symptoms. She lost 17 pounds over six months and had constipation requiring scheduled bowel medications. Severe nausea was ultimately identified as the primary trigger of presyncope and syncope. Dimenhydrinate provided minimal relief, and Emetrol, which offered only temporary benefit, was discontinued due to its high sugar content. Ondansetron, initially taken as needed, provided partial improvement; switching to scheduled dosing led to complete resolution of dizziness and syncope and improved appetite with weight regain. CT abdomen/pelvis revealed a mild hiatal hernia and gastric wall thickening suggestive of gastritis. Pantoprazole was initiated, and she was referred for EGD.

Conclusion: This case demonstrates that severe nausea can be an underrecognized precipitant of recurrent VVS in older adults. Morning medication timing and coffee intake likely heightened vagal activation. Scheduled antiemetic therapy and optimization of bowel habits prevented further episodes and improved overall function. Recognizing and treating gastrointestinal triggers, particularly nausea, can effectively prevent recurrent vasovagal syncope and reduce morbidity in older adults.

A15

Sporadic Creutzfeldt-Jakob Disease in Late Life

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Introduction

Rapidly progressive dementia (RPD) in older adults presents a critical diagnostic challenge. The differential includes acute, potentially treatable or fatal conditions like prion disease. Creutzfeldt-Jakob disease (CJD), the rare prototypical RPD, is increasingly recognized in older adults. Its presentation and progression has age-specific nuances. This case exemplifies classic and age-specific features of CJD.

Case Presentation

An 81-year-old male with a history of heavy alcohol and tobacco use was admitted with 7 weeks of progressive gait instability, vision

distortion, slurred speech, memory impairment, hallucination/delusions. On exam, he had decreased proprioception, restricted gaze, myoclonus, slurred and tangential speech, and orthostatic hypotension. Mental status slowly worsened showing loss of speech, orientation, and ability to follow commands. Empiric high-dose thiamine was ineffective, and labs were normal. Serial EEGs were unremarkable. Day 9 MRI demonstrated increased signal intensity in bilateral caudates and anterior thalami, classic of CJD. Day 12 CSF findings showed protein 54, normal WBC and glucose, negative autoimmune/paraneoplastic panel, negative cultures, and a positive RT-QuIC assay with markedly elevated T-tau (17,669 pg/mL) and 14-3-3 Gamma (134,381 AU/mL). Prion genetic panel was negative, confirming the sporadic form. The patient expired 12 weeks after symptom onset.

Discussion

This case exemplifies the diagnostic challenges of RPD in older adults. Early recognition of red flags (rapid progression, myoclonus, ataxia, and visual symptoms) is essential to distinguish CJD from routine dementias. Less common after age 75, CJD has faster progression; more frequent pyramidal signs, speech impairment, and akinetic mutism; and less frequent psychiatric or cerebellar symptoms.

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A16

Ethical Complexities of Suicide Risk During Hospice Transition in Advanced Cancer

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Background:

Depression and suicidal ideation in older adults with advanced malignancy present complex clinical and ethical challenges. When layered onto end of life decision making and hospice transition, clinicians must balance patient autonomy, safety, and quality of life.

Case Description:

An 84 year old man with a history of lymphoma and recent recurrence presented via emergency medical services after a suicide attempt involving self inflicted injuries and a fall. During hospitalization, he received evaluation by hematology-oncology, psychiatry and geriatrics. Medical assessment revealed no reversible contributors to depression or additional trauma related lesions. Despite medication adjustments and close monitoring, the patient persisted with active suicidal ideation. He was deemed to lack medical decision making capacity, therefore his surrogate participated in goals of care discussions. Given the recurrent malignancy and previously expressed wishes, the family elected for transition to home hospice services.

The discharge process involved interdisciplinary negotiation regarding ethical and safety concerns, hospice eligibility and protocols, and caregiver capacity. With ethics service guidance, the team facilitated discharge home with 24 hour caregiving under hospice care, acknowledging known risks.

Discussion:

This case highlights the challenge between ensuring patient safety and honoring patient centered end of life preferences in older

adults with terminal cancer. Institutional and hospice frameworks may not always align seamlessly with patient autonomy when active self harm risk exists. Collaborative multidisciplinary engagement was essential in defining an approach that respected the patient's wishes while mitigating risk to the extent feasible.

Conclusion:

Management of suicidal ideation in geriatric patients transitioning to hospice requires compassionate, ethically grounded decision making that incorporates patient and/or surrogate input, interdisciplinary expertise, and individualized risk-benefit assessment. This case underscores the importance of respecting personal dignity and goals of care even when clinical risk cannot be fully eliminated.

A17

Dignity in Care: The Advantages of Non-ICU Management for the Elderly

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Providers must weigh the risks and benefits for older adults who may qualify for an intensive care unit (ICU) service during hospitalization. We present a case of a 77-year-old female with a past medical history of monoclonal gammopathy of undermined significance, hypothyroidism, and pulmonary arterial hypertension, who presented to the hospital after a fall and was found to have a left intertrochanteric fracture. Six months prior to this admission, the patient presented with a fall, resulting in a femoral fracture. During that hospitalization, surgical repair of the hip fracture was complicated by systemic inflammatory response syndrome (SIRS), managed in the ICU with two pressors. She was weaned off pressors but required midodrine to manage persistent hypotension. A transthoracic echocardiography showed normal left ventricular ejection fraction of 76%, and thyroid studies and morning cortisol of 17.3 were normal. Following ICU discharge, the patient had poor mobility and required more assistance with her activities of daily living and was discharged to a rehabilitation center. The patient was weaned off midodrine after normalization of her blood pressure in the outpatient setting. She was slowly progressing in physical therapy and ambulating at home with a walker when she experienced another fall at home, resulting in this most recent hospitalization.

During this hospitalization, she again developed post-operative hypotension after surgery, and ICU services were considered. However, given the patient's moderate frailty (FI 0.33), with intact cognition, the decision was made to manage the patient on the floor, under the supervision of the geriatrics team. The patient was transfused with 1 unit of blood, slowly over 3 hours, and started on midodrine, which resulted in recovery of her blood pressure. The patient was subsequently discharged home with continued rehabilitation services; thus, reducing her length of stay compared to her prior hospitalization and preserving her functionality.

This case highlights the importance of avoiding the ICU in frail older adults. Studies have shown that the elderly in the ICU have a lower quality of life post-discharge, with a decline in physical functioning. Focusing on acute care management in primary and ward settings can enhance the quality of care and life for elderly patients.

A18

Bartonella endocarditis with secondary glomerulonephritis

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INTRODUCTION

Bartonella is a recognized cause of infectious endocarditis (IE)-associated glomerulonephritis (GN). Diagnosis is challenging given the typically negative blood cultures and potentially indolent presentation.

CASE

A 70-year-old woman presented to the emergency department for progressive nausea, fatigue, and a fifty-pound weight loss in the preceding year. She lived independently on a farm. Relevant medical history includes surgical aortic and mitral tissue valve repair for symptomatic aortic and mitral stenosis. Initial evaluation was significant for new petechial rash on lower extremities, severe malnutrition, and renal failure with creatinine 8.3 mg/dL from baseline 0.9 mg/dL three months prior; urinalysis revealed hematuria and proteinuria. Hemodialysis was initiated for uremia. Renal biopsy showed crescentic glomerulonephritis, with serologic studies identifying anti-proteinase 3 (PR3) antibodies and hypocomplementemia. Echocardiogram demonstrated vegetations on mitral and aortic valve prostheses. A diagnosis of secondary glomerulonephritis (GN) due to infectious endocarditis (IE) was made. Blood cultures remained negative, but serum *Bartonella henselae* PCR returned positive. The patient fostered kittens and had regular exposure to cats on her farm. Treatment with rifampin and doxycycline was initiated, as well as enteral feeds for malnutrition.

Two weeks into her hospitalization she refused nutritional support. She became withdrawn without focal neurologic findings. A diagnosis of demoralization was suspected: mirtazapine was trialed without improvement. CT head was obtained to rule out intracranial etiology for acute change in personality and mood. Multifocal infarcts were present, suspected to be septic emboli from endocarditis. She was not a surgical candidate for valve repair. The patient transitioned to a comfort-focused approach, with discontinuation of dialysis and discharge home with hospice.

CONCLUSIONS

Culture-negative IE can present with subacute, non-specific symptoms. *Bartonella* endocarditis is a cause of secondary GN and is associated with elevated anti-PR3 levels. Treatment for IE-associated GN is antibiotic therapy. Importantly, an abrupt change in mood and affect should raise concern for intracranial process even with a non-focal neurologic exam. In this case, head imaging provided key prognostic information that facilitated the patient's decision to transition to hospice.

A19

The Mimic: Case of Suspected Cholangiocarcinoma Revealing Primary Sclerosing Cholangitis

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Background

Klatskin tumors may be mimicked by conditions like primary sclerosing cholangitis (PSC) and IgG4-related sclerosing cholangitis. In PSC, MRI/MRCP can reveal multifocal strictures with bile duct dilatation, yet a dominant stricture may resemble cholangiocarcinoma. This case highlights the diagnostic difficulty of distinguishing malignant from benign biliary conditions and the potential perils of discussing goals of care in the context of an evolving diagnosis.

Case Description

An 81-year-old veteran undergoing evaluation for suspected cholangiocarcinoma presented to the hospital in September 2025 with abdominal pain. Basic laboratory studies were notable only for elevated alkaline phosphatase (alk phos) of 185. Given suspected cholangiocarcinoma, Palliative Care was consulted to discuss goals of care. Veteran was admitted for short-stay rehab at the VA San Diego Community Living Center (CLC) with a plan to subsequently discharge home on hospice. However, record review during his CLC stay questioned his diagnosis. In May 2025, CT abdomen/pelvis revealed a mass-like area near common bile duct concerning for cholangiocarcinoma; MRI/MRCP findings were similar. ERCP revealed a hilar stricture, but brushings/cytology were negative. CA 19-9, CEA,

and IgG4 levels were normal. Repeat ERCP with biopsies and fine needle aspiration (FNA) of a 15mm lymph node were also negative. Tumor board advised follow-up MRI in 2-3 months. MRI/MRCP in August 2025 again suggested a Klatskin tumor. ERCP/EUS revealed multifocal right bile duct; at that time alk phos was 280. FNA, cytology, biopsy, and brushings were pending at time of discharge but ultimately all negative. After reviewing multiple negative biopsies and tumor markers with GI, veteran's biliary strictures ultimately deemed more consistent with PSC. Plans for home hospice were cancelled, to the veteran's relief.

Discussion

Given the overlap and association between PSC and cholangiocarcinoma, maintaining suspicion for malignancy is appropriate. However, accurate differentiation is essential, as management differs significantly. This case underscores the importance of integrating all aspects of the diagnostic work-up and avoiding overreliance on a single modality, particularly when findings are discordant. It also highlights being cautious when initiating goals of care discussions amid diagnostic uncertainty.

A20

A Progressive Behavioral Dementia Unmasking Underlying Neuron Disease: A Case of FTD-ALS Overlap

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Background: Frontotemporal dementia (FTD) represents a heterogeneous group of neurodegenerative disorders characterized by early behavioral, executive, and/or language dysfunction. A subset of patients can develop comorbid amyotrophic lateral sclerosis (ALS), creating a challenging diagnostic course due to overlapping motor, cognitive, and behavioral features. Early identification of FTD-ALS overlap is crucial for prognosis, counseling, and management.

Case Presentation: A 68-year-old man presented to a Geriatric Assessment Clinic with a three-year history of progressive cognitive, behavioral, and motor changes. Symptoms began with gait disturbance, followed by significant behavioral changes 1-2 years later, including increased irritability, loss of interest in previously enjoyed activities, emotional blunting with reduced empathy, socially inappropriate behavior, and obsessive-compulsive traits and rigid routines. Subsequent decline included amnesic deficits and impaired executive function.

Collateral history and cognitive testing were consistent with a neurodegenerative process. Brain MRI demonstrated nonspecific atrophy, FDG-PET imaging was suggestive of FTD, and CSF and PET biomarkers for Alzheimer's disease were negative. Notably, initial neurological examination documented right-sided weakness, originally attributed to severe cervical degenerative disease. Over the next year, he developed progressive right upper extremity weakness and fasciculations. Repeat neurologic evaluation and electrophysiologic testing confirmed ALS, establishing a diagnosis of FTD-ALS overlap.

Discussion: Although FTD-ALS overlap is well recognized, it is frequently underdiagnosed due to variability in symptom onset and the tendency for motor signs to be subtle or attributed to comorbid conditions. Early behavioral alterations followed by executive and memory decline aligned with behavioral-variant FTD, while evolving asymmetric weakness and fasciculations ultimately revealed underlying ALS in this case.

Conclusion: Surveillance for motor neuron disease in patients diagnosed with FTD, especially when subtle motor abnormalities are present, is crucial as early recognition of FTD-ALS overlap informs prognosis, guides advance care planning, and enables timely multidisciplinary management.

A21

When Intubation Isn't an Option: Severe Legionella ARDS in a DNR/DNI Patient

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Introduction: Legionnaires' disease is a severe form of community-acquired pneumonia caused by *Legionella pneumophila* and is associated with high rates of respiratory failure and mortality. Despite improvements in treatment, 20-25% of hospitalized patients require invasive mechanical ventilation, and mortality in these patients remains up to 40%. Management becomes particularly challenging in older, immunocompromised adults whose expressed preferences limit invasive interventions.

Case Presentation: A 76-year-old woman with a history of B-cell lymphoma, subacute massive pulmonary embolism, independent and highly functional at baseline, was admitted with severe *Legionella* pneumonia and acute respiratory distress syndrome (ARDS). Despite worsening hypoxemic respiratory failure, she was firm in her decision to remain DNR/DNI. This presented a challenge as her goals of care excluded the intervention most likely to alter her trajectory. Non-invasive strategies such as alternating bilevel positive airway pressure (BiPAP) and high-flow nasal cannula (HFNC) were trialed with limited response. Despite guideline-directed antibiotics and corticosteroids per the CAPE COD trial, her respiratory status did not improve. As a result, the team engaged in complex decision-making and initiated tigecycline as salvage therapy. Over the ensuing days her respiratory status gradually and unexpectedly improved.

Discussion: This case highlights the complexities of providing goal-concordant care to older adults who choose DNR/DNI and face life-threatening illness. In severe ARDS, intubation is typically the definitive intervention. Honoring expressed limits on invasive treatment requires clinicians to recalibrate their approach. Clinical decision-making must integrate respect for autonomy, clear discussion about prognosis, treatments aligned with patient values, and what matters most to them, which is a core principle of the 5Ms framework. Tigecycline use reflects the individualized, creative approach needed when standard pathways are unavailable, demonstrating that honoring autonomy need not mean abandoning therapeutic creativity.

Conclusion: This case illustrates the clinical and ethical considerations in managing severe *Legionella* pneumonia and ARDS without intubation, and highlights opportunities for integrating the 5M framework to support goal-concordant care in high-risk respiratory failure.

A22

Anti-inflammatory lifestyle and supplementation inducing remission of newly diagnosed Lupus: a case study

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Background:

The role of anti-inflammatory diets has been a large component of Integrative and Lifestyle Medicine. This case highlights one incidence of a new diagnosis of lupus in an older adult which was treated with lifestyle modifications.

Case presentation:

88 year old female presented as a new patient to the Geriatrics clinic with complaints of chronic fatigue and generalized joint pain ongoing for several years. Her medical history includes hypertension, atrial fibrillation, iron and B12 deficiency. Differential diagnosis after initial visit was chronic lyme disease and inflammatory arthritis. Initial work up included CBC, CMP, TSH, as well as testing inflammatory markers ANA, cortisol and CRP. Results yielded positive ANA and elevated CRP to 9.18 (n= 0-3). She was advised to start an anti-inflammatory diet including elimination of gluten, supplementation of vitamin D and K. Additionally, she was started on a multivitamin with high B

vitamin component and omega 3. At her 1 month follow up, symptoms improved a little. Further work up showed a decrease in CRP to 3.11 and positive double-stranded DNA antibodies, elevated to 71 (n=0-9). The medication list was reviewed with no agents concerning for drug induced lupus. Lifestyle modifications above as well as addition of creatinine for generalized weakness saw a significant improvement in patient's symptoms. Rheumatology referral was given for further treatment options in light of new lupus diagnosis. Rheumatology consultation was scheduled 5 months after initial visit. At this time, labs were repeated. Inflammatory markers including CRP and dsDNA had normalized. Patient felt significantly better and continues to follow an anti inflammatory diet, along with supplementation in order to manage her symptoms.

Discussion:

Autoimmune conditions, like SLE, are centered in an inflammatory state. While treatment is conventionally rooted in steroids and more recently, biologics, this case highlights the importance of lifestyle modifications in alleviating symptoms and resolution of inflammatory markers. A simple change led to improved symptoms that had been ongoing for many years. Lifestyle modifications can be crucial in the first step towards symptom management. Stacking these modifications and supplements can create a much more powerful and long lasting effect than a single pharmacologic agent.

A23

Medication-Induced Delusional Parasitosis in an older Adult with polypharmacy.

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Delusional parasitosis is an uncommon psychodermatologic condition in older adults, often overlooked when symptoms appear to mimic true infestation. Polypharmacy increases vulnerability to perceptual disturbances, anxiety, and sensory misinterpretation. Early recognition of medication related causes is essential to prevent unnecessary antipsychotic use and to guide safe deprescribing.

An older woman in her late seventies presented with a one month history of sensations and visual perceptions of parasites on her arms, under the breast line, inside the ears, in the vagina, and on her wheelchair. She also reported seeing worms in her stool. She experienced anxiety related to these symptoms but denied low mood, memory loss, suicidal thoughts, or other hallucinations. Physical examination revealed seborrheic keratoses, intertriginous candidiasis, and vulvar lichen sclerosis, with no evidence of scratch marks or excoriations. No parasites were identified. Blood workup was normal, and stool studies revealed no pathogens. Her medication list included guaifenesin, benzonatate, hydrochlorothiazide, magnesium supplements, duloxetine, and chronic opioids, none of which had been started recently; she had been using these medications long-term. Several of these medications are known to cause hallucinations, formication, sensory misinterpretation, or delirium in older adults. A shared decision was made not to initiate antipsychotic therapy due to concerns about tolerability in an elderly patient and side effects, deprescribing was prioritized over antipsychotic therapy.

Guaifenesin, benzonatate, magnesium, and opioids were discontinued. Within days, she stopped reporting parasite sensations and no longer recalled experiencing them. Dermatology later confirmed benign skin conditions that explained her rash. She continued duloxetine and hydrochlorothiazide without recurrence of symptoms, supporting the diagnosis of medication induced delusional parasitosis.

This case shows that polypharmacy can trigger delusional parasitosis in older adults, especially when skin conditions are present. Because the patient had been using all medications long-term, the exact causative drug was unclear, and improvement occurred only after multiple medications were stopped, suggesting a combined polypharmacy effect. The case highlights the value of careful medication review, as timely deprescribing can avoid unnecessary antipsychotic use and improve outcomes in geriatric patients.

A24

Unmasking Latent Autoimmune Diabetes in Adults: A Case of Delayed Diagnosis in Late Adulthood

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Background: Latent autoimmune diabetes in adults (LADA) is a slowly progressive autoimmune condition characterized by the destruction of pancreatic β -cells in adulthood, resulting in a gradual decline in insulin secretion [1]. Clinically, it often mimics type 2 diabetes mellitus (T2DM), leading to frequent misdiagnosis. Diagnosis relies on detecting islet cell autoantibodies, similar to those found in type 1 diabetes mellitus (T1DM), although most patients with LADA test positive only for glutamic acid decarboxylase (GAD) antibodies [2]. According to the Immunology of Diabetes Society (IDS), LADA is typically diagnosed in individuals aged 30 years or older, although the exact age threshold remains under discussion [3].

Case Presentation: A 67-year-old Hispanic woman with hypertension and hypothyroidism was initially diagnosed with T2DM at age 62 and treated with oral antihyperglycemics. She presented with worsening glycemic control (HbA1c 9.7%), symptomatic hypoglycemia, unintentional weight loss, and a BMI of 22.7 despite adherence to therapy. Laboratory evaluation revealed markedly elevated glutamic acid decarboxylase (GAD) antibodies (>250 IU/mL), confirming autoimmune diabetes. Transition to a basal-bolus insulin regimen resulted in improved glycemic stability and resolution of hypoglycemia.

Conclusion: LADA can manifest in late adulthood and should be considered in older adults with unexplained poor glycemic control, weight loss, or hypoglycemia despite oral therapy. Early recognition and prompt initiation of insulin are crucial in preventing complications.

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A25

Reversing the “Wet, Wobbly, and Wacky”: When Dementia Isn’t Dementia — Shunt-Responsive Normal Pressure Hydrocephalus

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Background:

Normal Pressure Hydrocephalus (NPH) presents with gait difficulty, cognitive decline, and urinary incontinence and may be reversible with CSF diversion. This case highlights evaluation and functional outcome after shunt placement.

Methods:

A 70-year-old male had 2–3 months of worsening gait, falls, memory impairment, and incontinence. Exam showed broad-based magnetic gait and Mini-Cog 0/5. MRI/CT revealed ventriculomegaly. A 30 mL CSF tap test assessed reversibility. With improved gait, a VP shunt (Codman Hakim 200 mmH2O) was placed. Postoperative function, continence, cognition, and complications were monitored.

Results:

Tap test produced measurable gait improvement within 24 hours. After shunt insertion, ambulation and urinary symptoms improved further with PT/OT. Cognition stabilized. No infection, fever, or shunt malfunction occurred. The patient was discharged with continued progress and planned valve follow-up.

Conclusions:

Positive CSF tap testing predicted shunt response. VP shunt placement improved mobility and continence, demonstrating the benefit of early recognition and intervention in NPH to prevent misdiagnosis as irreversible dementia.

- Moderate – to – severe ventriculomegaly with patent aqueduct and preserved CSF flow through basal cisterns
- No mass or obstructive lesion



MRI Brain with CSF Flow Study

A26

A Case of Pembrolizumab-Induced Bullous Pemphigoid

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Background: Use of Immune Checkpoint Inhibitors (ICIs) has increased dramatically in recent years as treatment for a variety of cancers due to their efficacy and generally favorable side effect profile as compared to traditional chemotherapy. This makes ICIs especially compelling for older adults who may not tolerate adverse effects of treatment as well as their younger counterparts. However, ICIs carry their own risks, most notably immune-related toxicities, which can be severe and affect almost any organ system.¹ These risks may be under-recognized prospectively given the rapidly evolving use of these agents and under-representation of older adults in prospective studies. One such ICI-related toxicity is Bullous Pemphigoid (BP), an autoimmune dermatologic disorder primarily affecting older adults, and characterized by blister formation from autoantibody deposition at the basement membrane. We describe one such case of a BP flare secondary to an ICI, pembrolizumab, in a patient with Stage IIIC Lung Adenocarcinoma.

Case Presentation: A 70 y.o. man with stage IIIC lung adenocarcinoma and plaque psoriasis presented to the hospital with worsening diffuse bullous skin lesions. 2 months prior to admission, he had been diagnosed with pembrolizumab-induced BP via skin biopsy. Despite discontinuation of the ICI and undergoing outpatient treatment, blistering had progressed to involve the oral mucosa and required hospitalization. There, with guidance from Dermatology and Oncology, he was initiated on topical and systemic steroids, with a plan for initiating dupilumab, a biologic agent used to treat widespread skin toxicities associated with ICIs.

Discussion: This case demonstrates the potential for a protracted, serious cascade of events for an older adult diagnosed with an ICI-related toxicity. Though rare, drug-induced BP should be considered as a potential side effect of pembrolizumab treatment, particularly in an older adult with pre-existing dermatologic conditions, as they may be particularly vulnerable to severe or recurrent BP. More generally, clinicians ought to maintain a high index of suspicion for a variety of potential toxicities with ICIs, particularly in older adults with multi-morbidity, and engage in patient-centered risk/benefit discussions prior to use.

¹ Wang PF, C. Y. (2017). Immune-Related Adverse Events Associated with Anti-PD-1/PD-L1 Treatment for Malignancies: A Meta-Analysis. *Front Pharmacol*, 730.

A27

Finding Melanoma though Lymphadenopathy

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Background: Melanoma in older adults is associated with higher incidence, more aggressive disease, and often worse prognosis. Delays in diagnosis and suboptimal access to dermatologic care contribute to poorer outcomes, although recent advances in systemic therapies have improved survival.

Case Report: An 81-year-old woman with hypertension, hyperlipidemia, osteoporosis, and prior squamous cell carcinoma (SCC) presented to geriatrics clinic with a firm, right-groin mass. Pelvic ultrasound revealed abnormal lymphadenopathy. A follow up MRI revealed fluid collection in the inguinal area. During a routine dermatology visit her geriatrician recommended that she show the dermatologist her long-standing mole on her right thigh. The mole was biopsied, and the patient was diagnosed with stage III melanoma. Staging was negative for distant disease. She was started on pembrolizumab with good response, followed by wide excision of her right thigh lesion and right inguinal lymph node dissection. After her sixth cycle of pembrolizumab, surveillance imaging showed new metastases to the lung, bone, liver, adrenal gland, and brain. She transitioned to ipilimumab/nivolumab and received targeted radiation, but her disease continued to progress. Her course was complicated by a left pathologic femur fracture requiring ORIF and after discharge to SAR had continued progression and was ultimately transitioned to hospice where she died.

Conclusion: This case highlights how melanoma in older adults can present subtly yet progress rapidly and underscores the importance of evaluation of skin lesions in older adults. As age remains an independent adverse prognostic factor, the need for tailored prevention, early detection, and management strategies in this growing population is essential. It also emphasizes the need for a patient-centered, multidisciplinary approach including individualized risk assessment, careful treatment selection, proactive symptom management, and early palliative care integration to support quality of life throughout the disease trajectory.

A28

Cat Got My Muscle

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Introduction: Skin and soft tissue infections are commonly seen in Geriatrics. Our immune system gets weaker as we age, infections can take longer to heal. However, if the infection persists or gets worse, it is important to look for other causes or complications.

Case Description: Mr. S is a 78 y/o male with h/o HTN, HL, T2DM, Afib, Hypothyroidism, Dementia, Lumbar stenosis, Epilepsy, and ProstateCa s/p prostatectomy. Initially presented to ER with swelling and erythema of left leg from ankle to mid-shin after a cat bit the back of left calf 9 days prior to presentation. Received Unasyn, then discharged on oral Augmentin. 18 days after, He developed recurrence of left leg erythema, edema with acute onset of a posterior left calf fluid collection draining purulent material. He was seen at his Geriatrician's office, noted to have a 4 x 2 cm abscess. Bedside drainage was performed and treated with Doxycycline. 24 days post ER visit, developed low-grade fever of 99.4 F, visited again ER where workup was unremarkable and recommended to continue Doxycycline and dressing changes. 55 days post discharge, He presented to ER with ongoing erythema, edema, and purulence at left calf wound site. Pt found to have a 2 cm open wound on left calf with warmth and erythema extending to anterior left lower leg. MRI of left leg showed subcutaneous tissue edema and enhancement involving posterior calf compatible with cellulitis, a 10.1 x 2.5 x 1.6 cm lesion with peripheral enhancement centered within lower gastrocnemius and soleus muscles

and involving the achilles tendon, and a drainage tract extending from this lesion into posterior skin surface compatible with an intramuscular and intra-tendinous abscess and favored to be infectious myositis. Wound swab grew *Enterobacter cloacae* and *Bacteroides*.

Discussion: Pyomyositis is an infection of muscle leading to a collection of purulent material. It occurs more frequently in patients who are immunosuppressed or have diabetes and is often preceded by localized skin or soft tissue infection. It is caused in 90% of cases by *S aureus*. Patients can present with non-specific symptoms such as focal limb pain, muscle tenderness, and fever. MRI is the gold standard for diagnosis, shows muscle inflammation and intramuscular abscess formation. IR drainage of purulent material can help confirm diagnosis and identify the causative pathogen. Blood cultures are only positive in 5 to 30% of cases. Surgery may be required if there is extensive disease.

A29

The First Law of Motion: A Diagnosis at Rest, Remains at Rest

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Introduction:

There is often a hesitation to screen for dementia during acute hospitalization due to concerns that delirium or other medical conditions may impact cognitive function. Many commonly used screening tools are not validated for use in the inpatient setting. However, undiagnosed cognitive impairment can significantly influence health outcomes.

Case Presentation:

An 80-year-old man with a history of hypertension, heart failure with reduced ejection fraction (EF 25%), COPD on home oxygen, and chronic kidney disease, IIIa has multiple acute care presentations over a six-month period, many for falls within the home. Over this timeframe, concerns for cognitive impairment were noted by his primary care provider and by hospitalists. He had documented loss of iADLs and ADLs, worsening control of previously stable chronic diseases, and multiple missed appointments. He noted some struggles with his memory such as the name of his caregiver who has been around for a year, and directions to the grocery store. No screening for cognitive impairment was performed during these hospital encounters due to time constraints or competing acute medical priorities.

Discussion:

Despite a clear clinical concern, multiple opportunities to screen for cognitive impairment were missed in this vulnerable patient. Acute care encounters may represent an underutilized opportunity for such screening. If collateral informants are available, utilization of an informant-based screening tool such as the Ascertain Dementia 8-item (AD8) could circumvent many confounding factors which have made it difficult to validate other tools for the inpatient wards. If reliable collateral is not available, inpatient screening can still serve as a baseline to prompt and prioritize further evaluation once the acute illness has resolved.

Conclusions:

The formal diagnosis of dementia requires time and care to ensure accuracy and to provide education to patients and their families, but early diagnosis enables early intervention. Finding opportunities to screen for cognitive impairment, even if the setting is suboptimal, can create the diagnostic momentum necessary to prioritize the establishment of a diagnosis and ultimately influence health trajectory.

Ref:

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12064357/>

A30

Beyond Words: Communicating through Music in Hospice and Palliative Care

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Background: Music therapy has been widely used in palliative care; however, its physical and mental effectiveness remains unclear. It uses evidence-based, non-verbal methods to improve a patient's quality of life and comfort by managing symptoms and aiding communication and emotional expression.

Ms. L is a 96-year-old lady with a history of mild protein calorie malnutrition, anorexia, and dementia who is enrolled in home hospice. She is followed two times per month by a certified music therapist. Of note, she learned to play the piano as a child but has not played in more than a decade due to advancing dementia. Two months after starting music therapy and participating by humming, clapping, and tapping her feet to familiar songs and rhythms from her childhood, she walked over to the piano, lifted the cover, and began playing intricate melodious music.

While studies on palliative and end-of-life care (EOL) have documented benefits from music therapy such as improved quality of life and symptom management, the nature of this research is uniquely challenging. Anecdotal cases have also revealed that a strong therapeutic relationship between the patient and the music therapist is a key component of success. Our purpose was to evaluate the communication benefit of music therapy in patients with dementia at the EOL.

Methods: We conducted a case study of patients with advancing dementia who were exposed to music therapy at the end of life.

Results: Significant short-term improvements in emotional well-being, reduced agitation, and enhanced social connection were noted.

Conclusion: Music therapy is a safe, non-pharmacological approach to improving cognitive communication deficits in patients with dementia at the EOL. While dementia is a progressive condition, musical memory is often preserved longer than other cognitive functions, enabling music therapy to serve as a meaningful palliative tool.

A31

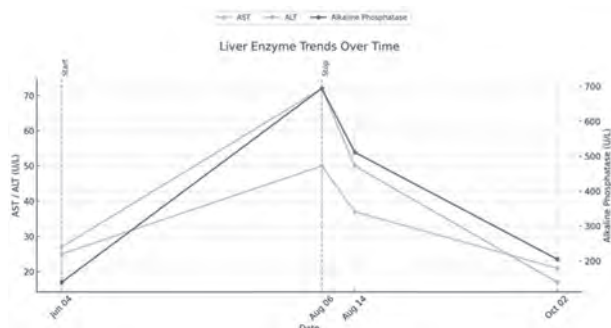
Tirzepatide-Associated Liver Injury in Older Adults: Vigilance Advised During Rapid Weight Loss and Systemic Illness

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Background: Tirzepatide, a dual GIP/GLP-1 receptor agonist used for diabetes and obesity, has shown significant benefits. However, recent case reports and post marketing data have identified rare cases of drug-induced liver injury presenting as hepatocellular or mixed pattern injury typically within 1 to 3 months of therapy. These events are generally reversible upon drug discontinuation, though rechallenge may worsen liver injury, suggesting a possible causal relationship. According to LiverTox, tirzepatide-associated liver toxicity is uncommon but clinically apparent warranting careful monitoring by clinicians.

Case Description/Methods: An 80-year-old woman with multiple comorbidities, including type 2 diabetes and obesity was transitioned from dulaglutide to tirzepatide in 1/2025 for better weight management. She did not experience initial weight loss but subsequently lost 18 lbs. rapidly over about a month without a preceding dose increase. This was associated with the onset of nausea, diarrhea, anorexia, pruritus, and fatigue. Laboratory studies showed new mild elevations in AST and ALT and a marked rise in alkaline phosphatase, with normal total bilirubin; prior hepatic panels had shown only mildly elevated alkaline phosphatase. Workup for viral and autoimmune hepatitis was negative. After discontinuing tirzepatide her liver enzyme abnormalities and symptoms resolved.

Conclusion: Older adults receiving tirzepatide should undergo careful monitoring for side effects with consideration for hepatic function testing before, during, and after treatment. Laboratory assessment is particularly important when patients experience systemic symptoms such as rapid weight loss and functional decline. This proactive approach may facilitate early detection of hepatic injury and optimize clinical outcomes.



A32

Traumatic Brain Injury in Older Adults

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Background

Delirium in hospitalized older adults is common, with causes often categorized as structural, toxic, metabolic, or infectious. Traumatic brain injury (TBI) is an important but frequently overlooked etiology, especially when cognitive changes are attributed to dementia or delirium. Early recognition is critical, as TBI has unique screening tools and treatments such as cognitive rehabilitation.

Case

A 70-year-old woman with hypertension, breast cancer, and osteoporosis presented after a motor vehicle collision with a T12 burst fracture. Pre-injury, she was independent in basic and instrumental ADLs. Vitals and labs were normal except for anemia. Initial brain imaging was negative for acute findings. She underwent urgent T10-L2 fusion. Postoperatively, she exhibited confusion without agitation. A geriatrics consult suspected her delirium was due to withdrawal from her home clonazepam. Despite restarting this home medication, her mental status did not improve. She was discharged to rehabilitation and later home. Four weeks after her original injury, she re-presented to the ED with surgical wound drainage and persistent cognitive deficits. MRI revealed an old right frontal subarachnoid hemorrhage. MoCA score was 14/30 with deficits in recall and attention. Persistent cognitive decline was attributed to TBI, though initial GCS was 15. She was referred for cognitive rehabilitation.

Discussion

This case illustrates the diagnostic challenge of TBI in older adults. TBI is an alteration of brain function, or other evidence of brain pathology, caused by an external force. This alteration may manifest as loss of consciousness, memory impairment, neurological deficits, or changes in mental status. Our patient meets this definition: she experienced persistent confusion and short-term memory loss after a motor vehicle collision. Unlike younger patients, geriatric TBI often presents as persistent cognitive deficits rather than classic symptoms such as headache or photophobia, leading to misattribution to dementia. Furthermore, Glasgow Coma Scale may underestimate severity in older adults due to cerebral atrophy and blunted physiologic response. Delirium and TBI can overlap clinically, as both involve acute changes in attention and cognition. However TBI represents a distinct pathophysiologic process that requires early recognition and intervention, including cognitive rehabilitation, to optimize recovery.

A33

Unusual backward falls in geriatrics as an early clue to progressive supranuclear palsy

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Background

Progressive supranuclear palsy (PSP) is a neurodegenerative condition with diverse manifestations. PSP is defined by the abnormal accumulation of tau protein aggregates in multiple brain regions. The mean age of onset ranges from 59 to 65 years. Reported survival varies across studies, but average life expectancy is approximately 7 years from symptom onset. At diagnosis, patients are typically about 3 years into their disease course. This diagnostic delay may be attributed to delayed medical attention and the under-recognition of early symptoms.

PSP is characterized by postural instability, ocular motor dysfunction and behavioral changes. Early PSP often presents subtly, with recurrent backward falls appearing years before diagnosis. Because geriatric falls are frequently attributed to frailty, sensory impairment, or medications, this atypical pattern is easily overlooked. We present a case highlighting how recurrent backward falls can serve as an early clue to PSP in geriatric practice.

Methods

The medical records were reviewed for details regarding the patient's case history. A literature review was conducted to contextualize the findings.

Results

A 66-year-old man presented with a two-year history of recurrent, unexplained, and frequent backward falls. This pattern was unusual for a geriatric patient without significant comorbid fall risks. His initial neurological examination showed preserved ocular motility, and his brain MRI was unremarkable.

His falls increased over time, and his exam was notable for a progressive limitation of vertical gaze. Family reported subtle cognitive and behavioral changes, including apathy and behavioral rigidity. He met criteria for PSP in the context of persistent backward falls, postural instability, vertical gaze palsy, and behavioral changes.

PSP is a clinical diagnosis with intervenable features. Literature reviews indicate that early falls in parkinsonism signal PSP and that prompt recognition can reduce unnecessary testing and guide management.

Conclusions

Early PSP may present primarily with unusual backward falls before the emergence of hallmark ocular motor abnormalities. Recognition of these early motor features in geriatric patients can reduce diagnostic delays, facilitate timely safety interventions, and improve patient and caregiver quality of life through multidisciplinary management.

A34

"Holy Smokes!!" - The Unfortunate Tale of a Rapidly Growing Abdominal Aortic Aneurysm in a Seriously Ill Older Adult with an Unsuccessful Surgical Outcome

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Background

Abdominal aortic aneurysm (AAA) is a progressive disease with high variability in growth rates, ultimately carrying a risk for fatal rupture. However, growth rates in older adults remain underreported, and balancing surgical benefits with risks remains a challenge.

Case

An 83-year-old male was transferred for AAA repair. He had a past medical history of hypertension, hyperlipidemia, chronic

kidney disease, COPD, AAA, and was a former smoker. He initially presented to an outside hospital with shortness of breath, thought to be due to COPD exacerbation and was treated with steroids, antibiotics, and nebulizers along with oxygen. On initial work-up at the outside hospital, CT imaging incidentally showed an infrarenal AAA measuring 6.6 cm with mural thrombus, which was previously documented as 5.5 cm in 2023. Transfer was coordinated for surgical repair. The patient lived at home, was partially dependent in ADLs using a rolling walker, and had no cognitive concerns. On presentation, he had no concerns, and his dyspnea had already resolved after initiating treatment for the COPD exacerbation. Physical examination was grossly normal including lung and abdominal exams. After completion of COPD exacerbation treatment, monitoring for incidental covid infection, and pre-surgical evaluation, the patient underwent thoracoabdominal branch endoprosthesis (TAMBE). However, post-surgical course was complicated by debility, dysphagia, and poor nutrition, which led to severe sepsis secondary to a sacral wound and osteomyelitis. Due to the irreversible nature of the post-surgical course, goals of care were shifted towards a comfort-focused approach with the patient subsequently dying in the palliative care unit surrounded by his loved ones.

Conclusion

Aging is a risk factor for rapid growth of AAA, along with its size, smoking history, and other comorbidities. Navigating surgical benefits and risks is particularly challenging for older, frail adults with AAA at high risk of rupture. It is important to recognize that even with optimal interprofessional collaboration and medical optimization tied with reasonable goals of care, survival might still be poor.

A35

Seeing the signs too late: A case of Late-Onset Amyotrophic Lateral Sclerosis

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Background: Late-onset amyotrophic lateral sclerosis (ALS) beginning after age 60, is often associated with diagnostic delay of ≥ 12 months compared to younger adults, stemming from a complex interplay of symptom misattribution, referral pathways, and provider recognition challenges. With our aging population, recognition of this subtype is increasingly important.

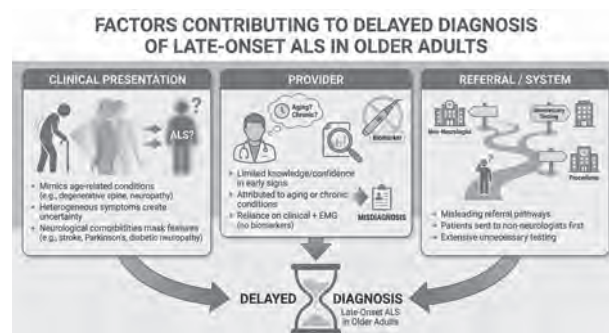
Case: 86-year-old female with PMH of Osteopenia, HTN, DJD of left shoulder diagnosed with ALS 6 months ago and now in nursing home due to severe upper and lower extremity weakness, dependent on powered wheelchair, and for all ADLs. Initial symptoms included back pain, muscle spasms, fatigue and bilateral leg weakness, managed as lumbar stenosis with analgesics, physical therapy, neuromodulators, and epidural injections with minimal improvement. Later, she developed left shoulder pain and weakness, treated with steroid injections. Over the next year, shoulder weakness progressed to left hand, and leg weakness progressed to hips, causing inability to stand, frequent falls, and wheelchair need. Neurological evaluation 2 years after symptom onset confirmed ALS.

Discussion: Delayed diagnosis in late-onset ALS is multifactorial.

Conclusion: Actively considering late-onset ALS in older adults ensures that subtle but significant neurological changes are not overlooked, enabling timely diagnosis and optimized care.

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Discussion

A36

TMP-SMX-Induced Stevens-Johnson Syndrome of the Penile Area in a Geriatric Patient

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Background/Objective/Research Question

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are rare, life-threatening mucocutaneous disorders with an incidence of 1-5 cases per million annually and adult mortality rates up to 25%. These conditions, primarily medication-triggered, pose risks in geriatric populations due to polypharmacy and age-related vulnerabilities. This case report highlights a rare presentation of TMP-SMX-induced SJS localized to the penile area in an older adult.

Methods/Study Design

Clinical evaluation included comprehensive medication review, physical examination with focus on mucocutaneous findings, laboratory assessment and structured follow-up care. Diagnosis was established through clinical assessment based on temporal relationships to drug exposure, characteristic physical findings, recurrence with re-challenge, and exclusion of alternative diagnoses.

Results:

The patient developed **localized penile skin erosions, desquamation, and sloughing** within days of initiating TMP-SMX following spinal cord stimulator implantation. Notably, he experienced an identical episode three months prior with TMP-SMX exposure during a trial procedure, which resolved spontaneously over weeks without medical intervention. Physical examination revealed localized skin erosions, desquamation and sloughing of the penile area most pronounced on the glans penis. Vital signs were stable. Lab findings showed mild anemia but were otherwise unremarkable. Management consisted of **immediate TMP-SMX discontinuation**, EMR documentation and hospital observation with supportive care. The patient's hospital course remained stable, and **lesions gradually resolved over several months** with conservative management.

Conclusions/Interpretations

This case demonstrates that a case of SJS/TEN with atypical, localized genital involvement in an older adult. Early drug withdrawal and comprehensive supportive care are vital in reducing morbidity and preventing severe outcomes in geriatric patients. The recurrence with re-exposure underscores the importance of thorough medication history and proper allergy documentation. Long-term dermatologic follow-up is essential, as genital scarring can continue developing for up to one-year post-injury, potentially causing significant functional impairment. This case underscores the importance of clinicians promptly recognizing atypical drug-induced mucocutaneous reactions in older adults to prevent lasting genitourinary issues.

A37

Challenges of Managing Delirium in Lewy Body Dementia

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Background: Lewy Body Dementia (LBD) presents with symptoms including fluctuating cognition, REM sleep disorder, and autonomic instability that complicate both diagnosis and treatment. Superimposed delirium is common in this population but can be difficult to recognize and even more challenging to manage due to overlapping symptoms, neuroleptic sensitivity and limited pharmacologic options.

Case Description: 73-year-old man with LBD admitted after a syncopal episode and was found to be in hyperactive delirium which was initially managed with Olanzapine. Subsequently, patient had episodes of tachycardia and severe hypotension prompting ICU transfer requiring vasopressors and dexmedetomidine sedation. Geriatrics was consulted for hyperactive delirium and inability to wean off pressors despite addition of Midodrine and Droxidopa. We recommended discontinuation of Olanzapine due to marked autonomic dysfunction. Midodrine and Droxidopa were discontinued and he was started on Fludrocortisone with stabilization of pressures. Low-dose trazodone was initiated with minimal benefit and thus discontinued. Due to limited options, benzodiazepines were initiated as a nightly dose and produced the most noticeable improvement. He was discharged but was readmitted four days later after a fall resulting in fractures. During the second hospitalization, he became hyperactively delirious again. Gabapentin was added to benzodiazepines as an adjunct but led to hypersomnolence and was stopped. Trazodone was cautiously retried with close blood pressure monitoring. Across both hospitalizations, consistent non-pharmacologic interventions, including frequent reorientation, cognitive stimulation, engagement with physical and occupational therapy, and active family involvement provided meaningful support.

Discussion: This case demonstrates the complexity of delirium management in older adults with LBD, where autonomic dysfunction, neuroleptic sensitivity and REM sleep disorder limit pharmacologic options. Notably, antipsychotics may exacerbate dysautonomia, potentially leading to hemodynamic instability. By emphasizing the limitations of commonly used agents in this population, this case highlights the need for an individualized treatment approach with a strong focus on non-pharmacologic strategies. A patient-centered, interdisciplinary approach may mitigate complications and improve outcomes for individuals with LBD experiencing delirium.

A38

A Silent Presentation of CAA: Persistent Hypoactive Delirium

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Background: Cerebral amyloid angiopathy (CAA) is a progressive, age-related small vessel disease characterized by deposition of amyloid protein in the blood vessels of the brain leading to vessel fragility. While lobar intracerebellar hemorrhage (ICH) is the classic presentation of CAA, prolonged hypoactive delirium, and transient focal neurological episodes (TFNEs) which are brief, disturbances in motor, sensory, or language function are frequently overlooked presentations and often correlate with cortical superficial siderosis and microbleeds on magnetic resonance imaging (MRI).

Case Description: 83-year-old woman with comprehensive geriatric assessment-based frailty index of 0.49, mixed vascular and Alzheimer's dementia presented to the hospital with acute confusion, lethargy and poor oral intake. Initial evaluation showed UTI and AKI with little improvement in mental status with treatment. She exhibited persistent hypoactive delirium, aphasia and episodes of lower extremity myoclonic jerks. Brain imaging showed severe chronic small

vessel disease and lateralized diffuse micro hemorrhages along the left single gyrus, left parietal lobe, and left cerebellum. Her symptoms were attributed to multifactorial toxic metabolic encephalopathy, and she was discharged to SNF for rehabilitation. During a comprehensive geriatric review at SNF admission, we identified her hypoactive delirium, TFNE-like episodes, and imaging findings were suggestive of a widespread cerebral event most consistent with CAA-related encephalopathy. Based on her severe premorbid frailty, widespread microhemorrhages, and persistent hypoactive delirium, she was at high risk for significant functional and cognitive decline with limited potential for neurological recovery. This guided a serious-illness conversation with her healthcare proxy, and she transitioned to hospice.

Discussion: This case highlights how CAA can masquerade as multiple acute conditions including toxic metabolic encephalopathy, infections, seizures, or TIAs. Hypoactive delirium and TFNE-like episodes, although subtle, are increasingly recognized as manifestations of CAA-related encephalopathy and should be considered in older adults with unexplained delirium, transient neurological symptoms, especially when neuroimaging reveals microbleeds or cortical superficial siderosis. Integration of cognitive baseline and frailty are essential for prognostication and prompt timely serious illness conversations.

A39

Navigating Care When Trust is Broken

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Mr. D is an 85-year-old former attorney living with his beloved wife. His medical history includes Alzheimer's dementia, coronary artery disease with five prior bypass graft surgeries, type 2 diabetes mellitus, hypertension, and chronic back pain with sciatica secondary to osteoarthritis. He has consistently denied his dementia diagnosis, discontinued follow-up with his primary care physician after being advised to stop driving, and since ceased all prescribed medications. Over time, his dementia has progressed, leaving him dependent on all IADLs and requiring assistance with ADLs. Despite these limitations, he remains physically strong and ambulatory yet lacks insight into his condition and resists accepting help. His wife and daughter provide devoted care and have developed effective strategies—such as distraction and emotional support—to maintain a balanced daily routine. However, they have been unable to overcome his deep mistrust of physicians.

A few days before his presentation to the Emergency department (ED) visit, Mr. D's wife was hospitalized following a fall, and his daughter had to travel out of town. Consequently, his son was called from out of state to assist with care. This disruption in routine led to dysregulated sleep and eating patterns, escalating agitation, aggression, and the onset of delusions and hallucinations, prompting his son to bring him to the ED.

Since admission, Mr. D has declined all medications and care interventions, including food and fluids. He exhibited visual and auditory hallucinations, profound confusion affecting his sense of identity, and severe sleep disturbance. His combativeness gradually subsided as his energy waned, but care delivery remained challenging without family present to mediate.

Our experience with Mr. D underscores the importance of understanding a patient's personality, values, and daily routines when providing care during periods of acute vulnerability. Recognizing the impact of recent disruptions allowed us to avoid an extensive workup for altered mental status, which would have further eroded his cooperation. Appreciating the vital role of family in offering context and emotional support enabled us to rely on them as essential partners in care.

Mr. D's story highlights the fragile foundation that enables individuals with dementia to thrive in the community—and how easily it can be destabilized, leaving many needs unmet.

A40

Diagnosing Hereditary Hemochromatosis in an Older Adult: A Frequently Missed Diagnosis of a Not So Rare Disease

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Hereditary hemochromatosis (HH) is one of the most common genetic disorders among persons of northern European descent (1 in 2-400). We know that HH can damage multiple essential organs including the liver and heart, but little research has been done on the cognitive impacts of HH. Case reports have described increased extrapyramidal and cognitive dysfunction in HH patients with increased prevalence of dementia and Parkinson's. Women often do not display symptoms, which are frequently nonspecific (fatigue, joint pain, weight loss), until after menopause, making timely diagnosis a challenge.

An 85 yo female with PMH of depression, CKD3, breast cancer, osteoporosis, primary hyperparathyroidism, and hypertension presented to clinic after her sister (age 70) was diagnosed with HH. The patient's family was also concerned about the patient's memory. Prior MOCA was 25/30 with patient functioning well. On chart review, the patient had been referred three years prior to hematology for a prolonged history of erythrocytosis. Given no concerning history and functional stability, the only recommendation was to monitor CBCs. Her hemoglobin since 2018 ranged from 14.4 to 16.7 without any secondary causes found. No iron studies were done until after the patient requested hereditary testing. Her ferritin was 326 with a serum iron of 175, TIBC 220, transferrin 80. HFE gene mutation C282Y was present (homozygous). HFE H63D (wild type) was NOT present. Abdominal ultrasound showed mild heterogeneous liver echotexture. The patient started on phlebotomy to maintain a ferritin level below 50.

Delayed diagnosis of hereditary hemochromatosis increases the risk of hepatocellular carcinoma, heart failure, and development of cognitive decline. We present a case of a patient diagnosed with HH in her 80s, several years after she was referred to hematology for erythrocytosis with no identified secondary cause. While population screening for HH is not recommended, iron testing is cost effective and may have led to earlier diagnosis and treatment. Fortunately our patient has not had progressive decline, but HH should be considered in older patients with erythrocytosis as treatment options exist that can prevent long-term consequences.

A41

When routine becomes critical: Sudden unilateral hearing loss after a salon visit

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Introduction

Hearing loss affects approximately 20% of the global population; however idiopathic sudden sensorineural hearing loss (ISSNHL) represents less than 1% of all cases. ISSNHL commonly occurs in middle-aged individuals and shows a higher prevalence among males. It is not typically associated with infection, trauma, ototoxic medications, inflammation, malignancy, neurologic or vascular disorders. We present a case of idiopathic unilateral sudden sensorineural hearing loss in a geriatric female patient.

Case

A 73-year-old woman with a history significant for osteoarthritis and stress-induced cardiomyopathy, presented with sudden-onset left-sided hearing loss. She was at a salon and noted the symptoms shortly after a hair wash and blow-drying session. She initially attributed the symptoms to having water in her ear. However, when the symptoms did not improve she sought an Ear Nose and Throat (ENT) physician evaluation. She had no vertigo, tinnitus, or ear pain, and had no neurologic, infectious, or traumatic antecedents. She had no exposure to ototoxic medications. Magnetic resonance imaging (MRI) of the brain was unremarkable. Oral steroids were started within seven days of symptom onset. However, despite timely initiation of oral

corticosteroids, her hearing loss persisted, and she was subsequently treated with intratympanic steroid injection.

Discussion

Sudden sensorineural hearing loss (SSNHL) is defined as rapid onset of hearing loss within 72 hours. Potential etiologies include neoplastic, infectious, autoimmune, neurologic, otologic, metabolic, and vascular disorders, as well as exposure to ototoxic agents and trauma. However, many cases are idiopathic. ISSNHL most commonly presents in middle-aged individuals, between forty to fifty years of age, with a higher prevalence among males. Treatment includes oral or intratympanic steroids. Steroid initiation within seven days of symptom onset is associated with higher likelihood of complete hearing recovery. Geriatric patients with ISSNHL generally have a poorer prognosis and lower likelihood of recovery. In this case, the association of hearing loss with a hair wash and blow-drying session delayed the patient in seeking an ENT evaluation as she attributed symptoms to water in her ear. This case highlights the importance of recognizing sudden sensorineural hearing loss as a medical emergency and seeking timely medical attention.

A42

Facelift Gone Bad? Not Quite: A Case of Progressive Motor Neuron Disease

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It's not often we see facelifts in geriatric patients. However, older patients can safely undergo the procedure and achieve excellent, natural-looking results, provided they are in good overall physical and mental health. Routine facelifts can cause injury to fine sensory or motor nerves in the face, but this is temporary. Function and sensation typically return within a few months as nerves heal and swelling subsides.

Facial Onset Sensory and Motor Neuronopathy (FOSMN) is a rare, progressive motor neuron disorder, classified similarly as amyotrophic lateral sclerosis (ALS), that begins with facial paresthesias and progresses to involve muscle cramps, weakness, and atrophy over time. Dysarthria and dysphagia can also occur. A hallmark feature is absent corneal reflex. Although there is no known causality between facelifts and FOSMN, the persistence or worsening of neurological symptoms should raise concern for FOSMN, and not just be attributed as a complication of a facelift. Treatment options are limited and minimally helpful. IVIG has been shown to improve symptoms in some patients which has raised questions about autoimmune involvement. Very few patients have had mild clinical improvement with plasmapheresis and/or steroids.

82 y/o female, with a past medical history of GERD, lumbar disc disease, depression, and protein-calorie malnutrition, was admitted to a long-term care facility due to family being unable to continue taking care of her. She had undergone a cosmetic facelift, which led to facial droop 2 months later. A nerve conduction study confirmed a compressive lesion of the left facial nerve. She did therapy and had facial nerve stimulation with some improvement until 2 years after, when she experienced regression, dysarthria, and dysphagia, requiring PEG tube. Ultimately, she was diagnosed with progressive motor neuron disease. She also developed limb weakness and hyperreflexia. Despite remaining at home, her illness progressed, rendering her wheelchair-bound. She has since developed neurogenic bladder, absent corneal reflex, utilization of geri-chair, and symptoms have continued to progress.

FOSMN is a progressive, incurable condition, though its disease process is often slower than other motor neuron diseases. As symptoms may be coincidental after facelift surgery, primary care providers should be aware of this rare and progressive disease.

A43

The perils of fragility: Cascading events after an osteoporotic fracture in an independent older adult

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Osteoporosis-related fractures are responsible for more hospitalizations than heart attacks, strokes, and breast cancer combined¹. Furthermore, hip fractures are associated with an estimated 20% increase in mortality risk in the year following the fracture¹. This case report documents the perilous and cascading course that can follow an osteoporotic fracture.

A 90-year-old health care economist who exercises daily suffered a right intertrochanteric fracture due to a mechanical fall from standing. He was hospitalized and underwent fixation with cephalomedullary nail the same day. Approximately 10 days later while at acute rehab he developed mild leg pain and was diagnosed with an acute DVT in the uninjured left lower leg. Subsequently, he developed significant pain in the right hip & leg and at his first orthopedic visit 3-4 weeks after surgery was found to have failure of fixation with “screw cut out and varus collapse” of the femoral head. After a thorough discussion of treatment options and patient goals, the decision was made to proceed with surgical revision. Other PMH was notable for CAD s/p CABG, paroxysmal AFib/Aflutter, vertebral compression fracture, and mild venous insufficiency. Pre-op evaluation was significant for resolution of LLE DVT, AFib on EKG, and normal LV & RV function on TTE. His operative course was significant for an estimated 800mL of blood loss, hypotension, and bradycardia. While in the PACU he suffered cardiac arrest. After approx. 5 minutes of CPR, he regained a pulse and was transferred to the SICU. Chest CTA was negative for PE. He was extubated and weaned off vasopressor support within 24 hours. Palliative Care was consulted due to his initial request to discontinue all interventions, but this was updated the next day to avoiding re-escalation of care and proceeding with rehabilitation.

This case of a relatively healthy, previously independent 90-year-old man who survived post-op cardiac arrest following hip fracture revision surgery illustrates the importance of considering the risks & benefits of osteoporosis screening and treatment, such as initiation of pharmacologic therapy after fragility fracture, in all appropriate populations, including men age 70 & above.

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A44

Value of geriatric expertise in the inpatient care of heart failure in older adults

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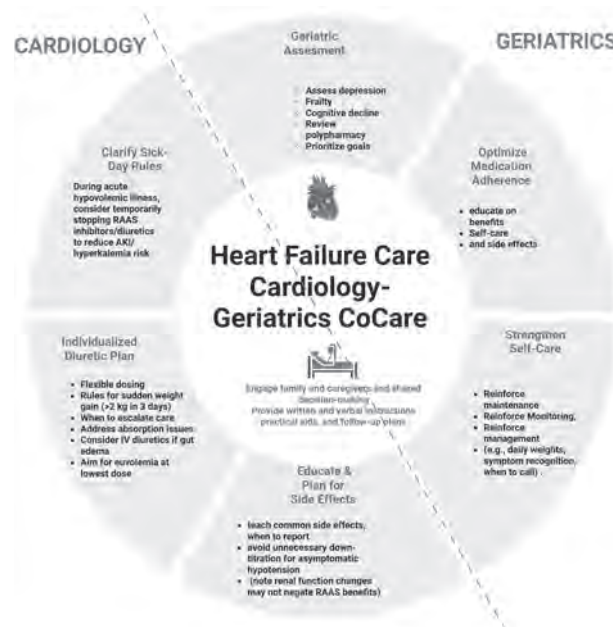
Background: HFpEF is a geriatric syndrome requiring awareness of age-related vulnerabilities. Comprehensive geriatric assessment identifies barriers to self-care and medication adherence in older adults hospitalized with heart failure but remains underused. This case shows how geriatricians can improve inpatient outcomes through targeted assessment and intervention.

Methods: A 69-year-old African American female was hospitalized ten times in 2025 for heart failure exacerbations. During her last admission, geriatricians co-managed care with cardiology. Prior testing showed mild cognitive impairment (MoCA 19/30). Assessment revealed limited understanding of heart failure, unreliable transportation and caregiver support, and lack of self-management tools (e.g., home scale). Geriatric involvement supported shared decision-making aligned with her health literacy.

Results: At discharge, she received a home scale, care manager support, and follow-up in geriatrics and specialty clinics. Despite

transportation barriers and missed visits, she avoided rehospitalization for 2.5 months utilizing virtual visits.

Conclusions: Collaborative geriatric and cardiology management (Figure) is essential for addressing geriatric syndromes in heart failure, improving adherence, and strengthening self-care. Patient-centered geriatric care and focused transition planning may reduce hospitalizations and enhance quality of life for older adults with complex needs.



A45

Patient distress in new-onset neurologic symptoms: A case comparison

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Background: Unexplained neurologic symptoms can cause severe patient distress. The absence of a clear organic cause can frustrate both patients and providers.

Methods: This case comparison examines two patients who presented with debilitating symptoms. While neither workup identified a neurodegenerative cause, both patients improved in the context of appropriate workup, targeted non-pharmacologic therapies, and/or treatment of mental health conditions.

Results:

Patient A is a 78-year-old woman with a history of hypertension and fibromyalgia who presented with one month of memory change, delusions of harm, and inability to perform ADLs. On exam, she had soft speech, pervasive delusions, and psychomotor slowing that prevented her from completing the interview. Evaluation ultimately included extensive bloodwork, lumbar puncture, EEG, and pelvic imaging due to concern for autoimmune encephalitis. Testing was negative apart from hyponatremia secondary to SSRI, which had been initiated after symptom onset. The team ultimately concluded that her symptoms were consistent with new onset generalized anxiety disorder. She completed speech, physical, and occupational therapies. She is now treated with low dose gabapentin and psychotherapy with near complete resolution of symptoms.

Patient B is a 66-year-old woman with a history of generalized anxiety disorder and vestibular neuritis who presented with years of tremors, urinary incontinence, and cognitive decline that had worsened over the last 6 months. She had mild impairments on neuropsychiatric testing and a coarse tremor of upper extremities and neck. There was

concern for multiple system atrophy given prominent speech deficits, dysphagia, and autonomic symptoms, however following neurology consult her symptoms were thought to be most consistent with a functional neurologic disorder. Patient received physical and occupational therapy, started buspirone, and has attended support groups. She has had overall improvement in her symptoms, though her tremor has continued.

Conclusion: While it is important to consider neurodegenerative conditions in the differential of new functional impairments, organic diagnoses may be elusive. Negative results can initially frustrate patients and providers but should not represent the “end” of the case. In these examples, ongoing attention to patient complaints and engagement from providers led to functional improvement, even in the absence of a neurodegenerative diagnosis.

A46

Anorexia as a Manifestation of Post-Stroke Depression

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Background

Post-stroke depression affects over half of survivors in the first year and, with appetite changes, contributes to malnutrition and failure to thrive in up to 62% of patients^{1,2}.

Case 1:

A 67-year-old female with history of left pontine infarct with residual right-sided hemiparesis had ten hospitalizations for dizziness within two months post-stroke. Her imaging and examination were not consistent with vestibular causes. She was eating only 10% of meals and had intermittent hypotension and hypoglycemia. Geriatrics was consulted with concern for failure to thrive. She endorsed guilt regarding dependence on family. Escitalopram was increased to 10 mg and mirtazapine added per psychiatry. Family was encouraged to bring preferred foods. By the end of her 3-week stay, meal intake improved to 50–75%, and she was discharged home.

Case 2:

A 41-year-old female on hemodialysis for 10 years, with recent basal ganglia hemorrhage and residual right-sided weakness, depression, and PTSD was admitted from subacute rehab due to decreasing oral intake and intermittent refusal of dialysis. Methylphenidate, mirtazapine 15 mg, and megestrol 40 mg produced no improvement. Palliative care was consulted when she refused PEG placement; she later agreed with family support. She was intolerant of tube feeds and continued intermittently refusing dialysis after returning to rehab. She passed away 5 months after her stroke.

Discussion:

In stroke patients, the mechanisms underlying appetite changes include cranial nerve palsy, difference in smell/taste and distaste of texture modified diets. Evidence for appetite-stimulating medications in hospitalized stroke patients is extremely limited. Agents such as dronabinol, megestrol acetate, and mirtazapine show limited ability to improve appetite or intake and do not produce meaningful weight gain². In both of our patients, there was limited appreciable difference from pharmacological intervention, which often leads to detrimental prescription cascades and undesired adverse effects.

Conclusion:

In the absence of post-stroke dysphagia, decreased oral intake should raise concerns for depression, warranting timely multidisciplinary interventions with an emphasis on goal-concordant care.

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A47

IT'S NOT JUST YOUR TOE! Incorporating the Geriatric 5 M framework to Post Acute Care referrals exposed a lot more than the main reason for consultation.

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Objective: The use of 5M framework in evaluating Community Living Center (CLC) consults in San Juan, Puerto Rico VA helped diagnose geriatric syndromes beyond main reason for consultation.

Background: In post-acute care, often reasons for consultation are antibiotic and local wound care for an infected toe. This may seem simple with a predictable length of therapy consistent with short stay of <100 days; however, when we look beyond the primary diagnosis, in this case, “A TOE”, incorporating the 5 M framework for geriatric care (Mind, Mobility, Medications, Multimorbidity, and What matters most) for comprehensive geriatric assessment allowed us to diagnosed geriatric syndromes and missed opportunities which often lead to longer lengths of stay.

Method: We reviewed 6 non-consecutive cases consulted to CLC FY25 QTR4 for a toe :3 left 1st toe osteomyelitis (OM), 2 left 5th toe OM, and 1 right 3rd toe gangrene. Retrospective data was collected focusing on demographics, clinical characteristics, and selected clinical outcomes. Descriptive statistics used to summarize data.

Results: Age ranged 49-77. Cases reviewed all but 1 exceeded the initially projected length of CLC stay. Two out of 6 cases were newly diagnosed with Dementia, 3 with frailty, 3 with Osteoporosis, 3 with hearing loss, and 2 with a sleep disorder. All 6 cases had polypharmacy and deprescribing at least 1 medication was recommended. A “TOE” is a small area, yet it can reveal information such as hygiene, cognitive impairment, judgement, comorbidities such as neuropathy, Diabetes, and PVD. All 6 cases had either heart, metabolic, renal condition or a combination. At least 1 geriatric syndrome was diagnosed in all cases reviewed. Workup ordered also led to other diagnoses such as pacemaker associated heart failure, NSTEMI, and vanishing biliary duct syndrome. We had two younger veterans (49, 61); however, using the framework under the premise that they were both medically compromised proved to be useful for the “functionally geriatric patient”.

Conclusions: The use of 5M framework in our CLC consultation allowed us to newly diagnose geriatric syndromes, including frailty, dementia, polypharmacy, and multimorbidity beyond reason for consultation. Also highlights aspects of the patient's health goal and overall wellbeing that provide individualized care and advanced care planning.

A48

No Longer Just Geriatric: Adults Under 65 in Nursing Homes

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Introduction: Most individuals receiving long-term services and supports (LTSS), or assistance with ADLs/iADLs, live in the community and are under the age of 65. From 2018–2021, home- and community-based LTSS use increased while institutional use [nursing homes (NH), group homes, mental health facilities] declined. More recent 2022 data show both rising. The majority of institutional LTSS users reside in NHs. Although most NH residents are >65, a striking 20% of residents are under the age of 65—a proportion that rose from 10% in 2000 to 16% by 2017. While NH admissions for older adults with disabilities have fallen sharply, admissions for younger adults show a recent upward trend, indicating a growing population.

Case Description: A 51-year-old man, employed at a grocery store and actively managing his health (regular exercise, nutrition follow-up), presented for routine primary care in 2022. That year, his mother returned home from the hospital but was unable to qualify

for home health services due to income. In 2023, the patient had two ER visits after toxic exposure while self-managing a rodent infestation. That year, his mother's primary care provider suggested they move to a group home together; by end of year, his mother had died. Throughout 2024, the patient had near-monthly PCP visits reporting feeling overwhelmed, expressing housing and food insecurities, anxiety, and ultimately had lost 20lbs by end of the year. In early 2025, he suffered bilateral lower extremity frostbite requiring amputations and developed a sacral wound, leading to nursing home admission. It wasn't until after his NH admission that concern for intellectual disability was acknowledged.

Discussion: Younger adults (<65) now form a distinct NH subpopulation with higher rates of severe physical disability, mental-physical multimorbidity and limited social supports—characteristics mirrored in our patient. Current NH models, designed primarily for older adults, poorly address the rehabilitative, psychological, and social needs of this younger population. These trends underscore the urgent need for (1) community-based alternatives tailored to younger adults at risk of premature NH placement and (2) increasing targeted education for NH providers and staff on unique care needs of younger adults with disabilities.

A49

When Dementia Is Not The Cause

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Background: Dementia is often diagnosed in older adults with cognitive decline and personality changes. However, other etiologies should be considered, especially when symptoms rapidly progress.

Case: An 83-year-old male with HTN, DM2, CKD3, depression, and remote DLBCL involving the testicle (s/p orchidectomy and chemo-XRT) was in remission on testosterone replacement. Over two years, he began to fall, and his family noted increasing impulsivity, obstinance, and abusive verbal outbursts. Testosterone, TSH, free T4 and vitamin levels were normal. Initial brain MRI with contrast showed small vessel disease and moderate volume loss. He was diagnosed with dementia with unmasking of an undiagnosed psychiatric disorder. Symptoms progressed despite physical therapy and psychiatric medication adjustment. He presented to the ED with encephalopathy, weakness, and ongoing falls. Head CT revealed new edema in the left frontal lobe, splenium, and left cerebellum (annotated images available). Brain MRI suggested metastases and chest CT showed a left lung mass and lymphadenopathy (presumed primary malignancy). He received dexamethasone and valproate for seizure prophylaxis, and two weeks of WBRT which improved his encephalopathy. One month later head CT showed decreased vasogenic edema. Hospice was initiated, and he died at home.

Discussion: Older adults with changes in cognition, mood and personality must undergo a thorough investigation. Encephalopathy or psychiatric changes may be the only symptom of brain tumors. Metastases in the anterior cingulate gyrus and splenium likely caused this patient's progressive emotional lability despite psychiatric treatment. Metastases in the left precentral gyrus contributed to motor weakness and lesions in the cerebellum precipitated discoordination and falls. Brain radiation and corticosteroids can alleviate symptoms by decreasing vasogenic edema and tumor size. Clinicians must have a low threshold for additional testing, including imaging, especially in cases of rapid clinical progression or unanticipated treatment response.

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A50

Endocarditis in the Elderly: A Case of Missed Signals and Lessons Learned

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Infective endocarditis (IE) in elderly patients with prosthetic valves often presents without fever, leukocytosis, or classic stigmata, and echocardiography has reduced sensitivity in TAVR recipients. These factors contribute to delayed recognition and a high risk of embolic complications. This case highlights missed opportunities and diagnostic challenges leading to delayed diagnosis of prosthetic-valve IE caused by *Streptococcus parasanguinis*.

An 82-year-old woman with TAVR (2023) and a Watchman device (2024) developed progressive fatigue, weight loss, anemia, and back pain. A markedly elevated ESR (120 mm/hr) was recorded on January 28, 2025, but attributed to chronic disease. Over the next several weeks she had multiple presentations for hypotension, chest pain, and arrhythmias. On March 6, she experienced an acute myocardial infarction caused by thrombus in the left main and circumflex arteries requiring aspiration thrombectomy. The event was considered embolic from valve-associated thrombus. A cardiac CT subsequently showed a mass on the aortic valve described as thrombus versus vegetation, with PET imaging recommended. Transthoracic and transeophageal echocardiograms showed no vegetations, consistent with known limitations in TAVR-associated IE.

During an April 9–10 admission for hypotension and new atrial flutter, blood cultures were obtained for the first time and grew *Streptococcus parasanguinis*, confirming subacute IE. The CT mass was later regarded as most likely vegetation. She completed six weeks of intravenous ceftriaxone with microbiologic cure.

This case illustrates how nonspecific symptoms, anchoring on chronic disease, lack of fever, and negative echocardiography can delay IE recognition in elderly prosthetic-valve patients. Elevated inflammatory markers, unexplained constitutional symptoms, and any embolic event in a TAVR recipient should prompt early blood cultures and multimodal imaging. A high index of suspicion is essential for timely diagnosis in this vulnerable population.

Key Clinical Events

Date	Event
Jan	ESR 120 noted outpatient
Mar 6	Coronary embolus; CT mass thrombus vs vegetation
Apr 11	Blood cultures positive for <i>S. parasanguinis</i>

A51

Rapid Airway Compromise From A Nasopharyngeal Mass in an Older Adult: The Critical Role of Goals-of-Care Discussions During Diagnostic Uncertainty

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Rapidly progressive head and neck masses in older adults pose unique challenges. Beyond diagnostic uncertainty and airway risk, these cases require timely goals-of-care discussions and advance care planning due to the potential for sudden deterioration before a treatment plan is established. Nasopharyngeal lymphoma is an uncommon but potentially aggressive cause of upper airway obstruction in geriatric patients.

A 73-year-old woman presented with a rapidly enlarging nasopharyngeal mass associated with worsening dyspnea, dysphagia, and dysphonia. She underwent endoscopic biopsy; however, prior to receipt of pathology results, she experienced abrupt decompensation followed by cardiopulmonary arrest. She was successfully resuscitated and intubated. Given persistent airway instability and the anticipated need for prolonged ventilatory support, a tracheostomy was placed. Diagnosis was delayed due insufficient cells obtained during biopsy, necessitating multiple biopsies. Final pathology confirmed lymphoma, and systemic chemotherapy was subsequently initiated. Throughout her hospitalization, rapid shifts in prognosis prompted repeated

goals-of-care conversations with the patient and family, clarifying her preferences regarding life-sustaining treatments and aligning the care plan with her values.

This case illustrates the complexity of caring for older adults with rapidly evolving airway pathology, where deterioration may outpace diagnostic timelines. In geriatric populations—who often have multimorbidity, frailty, and varying thresholds for invasive interventions—early and consistent goals-of-care discussions are essential. Advance care planning ensures that emergent interventions are pursued in a manner consistent with the patient's wishes. The case also highlights the importance of interdisciplinary collaboration among geriatrics, critical care, and oncology to balance acute stabilization with person-centered decision-making.

Rapidly progressing nasopharyngeal lymphoma in older adults can result in life-threatening airway compromise before a diagnosis is confirmed. Goals-of-care discussions and attention to advance care planning are critical components of high-quality geriatric care, ensuring alignment of emergent interventions with patient values during periods of diagnostic uncertainty and clinical instability.

A52

Paroxetine Associated Musical Hallucinations in the Setting of Dementia with Lewy Bodies

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Background: Musical hallucinations (MH) or musical ear syndrome, is a rare auditory occurrence in which a person perceives music or aspects of music in the absence of ambient auditory stimuli. MH is generally nonpsychotic in nature. While frequently seen with hearing impairments, MH is also associated with drug effects, advanced age, female gender, neurodegenerative disease (particularly Dementia with Lewy Bodies), structural brain disease and psychiatric illness. There have been occasional cases of MH recognized in the setting of cognitive impairment or with SSRI use, no case reports exist in the setting of both.

Case: Mr. T was a 91-year-old male with medical history of CAD and hypertension, who presented to the outpatient geriatric clinic initially with memory complaints. At that time, he had no psychiatric history or hearing impairment and was able to perform all ADLs and IADLs. He was noted to have mild cognitive impairment. He was seen in follow-up 5 months later, having been hospitalized in the interim multiple times for unrelated conditions. His memory had declined, now with paranoid delusions and hypersexuality. Paroxetine at 20mg/d was initiated to combat mood and hypersexuality. On day 21, he developed complex MH described as hearing a cantor (Jewish clergy) singing every morning. He was given a drug holiday, during which singing stopped, but previous behaviors returned. A CT brain showed moderate age-related volume changes. He was given a diagnosis of Dementia with Lewy Bodies 41 days later, when his SLUMS score was 8, with more visual hallucinations, limited speech, and inability to stand or ambulate. Mr. T expired on day 90.

Discussion: This case highlights the potential association between musical hallucinations and the use of paroxetine. It adds knowledge to the complex interplay between medication side effects, psychiatric syndromes and neurodegenerative disease, emphasizing the need for continued research to elucidate underlying mechanisms such as anticholinergic states and Lewy body disease.

A53

Dentures in Dementia: Dangerous?

R. Motarjemi. *Geriatrics, UCSD, San Diego, CA.*

75-year-old male with past medical history of hypertension and Alzheimer's disease was brought to hospital ED with chief complaint of restlessness.

Patient was a resident of a memory care facility. He had been fine and at baseline till 2 days prior, when he started to become restless. Patient himself had no complaints. Per staff gradually became more restless, not

eating or drinking much. No report of worsening confusion or cognition decline. Per family request, was transferred to ED for workup.

In emergency department vital signs were stable. Physical exam was unremarkable except mid epigastrium tenderness in deep palpations. Chest Xray showed partial visualization of a linear metallic density object projected over the anterior bowel on the lateral. KUB confirmed a metallic density projecting over the mid-upper abdomen, likely in the region of the gastric antrum, possible metallic portion of a dental bridge. (IMAGE) Patient was admitted and ultimately, he had laparoscopic removal of foreign body from stomach by general surgery. Patient was in hospital for 7 days and was sent back to facility.

Upon discussion with facility, it appears that patient had dentures that he was using and the staff at facility were not monitoring its use. They had not noticed that part of the denture was gone and missing.

The use of dentures in patients with dementia presents unique challenges but is often necessary to maintain oral health, nutrition, and overall quality of life.

Dentures can pose certain risks and challenges for individuals with dementia. Individuals with dementia may confuse their dentures with food and attempt to chew or swallow them, leading to a risk of choking or aspiration. Swallowing them can cause abdominal pain or perforations and it requires immediate attention.

While there are no specific guidelines for use of dentures in demented patients, it is necessary to have process in nursing facilities and memory care units to monitor use and storage of dentures.

A54

Forgotten From Forties

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81-year-old Arabic speaking Iraqi woman with past medical history of hypertension brought in by family with chief complaint of abdominal pain. Patient stated for the last three years has been having intermittent abdominal pain mostly in the lower abdomen. Last three days pain has become more severe happening at less intervals. She had low grade fever. No nausea or vomiting or diarrhea. No urinary symptoms. In ED, normal vitals and physical exam only showed lower abdominal tenderness. Imaging showed an object in uterus which could possibly be an intrauterine device. (IMAGE)

Upon questioning, she said that she has had an IUD planted 40 years ago in Iraq. It was never removed and upon immigrant into America 10 years ago and she had totally forgot about it. Her primary care had never asked about her sexual history, and she had declined to have pap smears. Patient was referred to Gynecologist and had laparoscopic surgery to remove the device due to adhesions.

Healthcare providers play a crucial role in promoting sexual health among older adults, an important yet often neglected aspect of aging well. Social and cultural beliefs, embarrassment or shame and perception of irrelevance are some of the reasons elderly women shy away from such conversations. Time constraints, discomfort or lack of training and focus on age-related health issues can result in physicians prioritizing other health concerns perceived as more urgent.

Clinicians should include comprehensive sexual health history and assessments as part of routine care. They should try to have discussions about sexual history and sexual health with elderly patients, areas often left unspoken due to stigma or discomfort.

A55

Beyond BPH: Symptom-Driven Discovery of Prostate Cancer

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Introduction: Lower urinary tract symptoms in older adults are often attributed to benign prostatic hyperplasia, delaying evaluation for prostate cancer. Although guidelines discourage routine PSA testing in men over 70, studies show that symptom-driven testing can identify aggressive cancers while avoiding overdiagnosis. Newer

screening strategies combining PSA with biomarkers and MRI have demonstrated improved detection and may be relevant when older adults present with persistent or unexplained symptoms.

Case: An 82-year-old man with no family history of prostate cancer presented with nocturia, dysuria, and pelvic discomfort. Because pelvic discomfort suggested an etiology beyond BPH, a PSA was obtained and was 9.9 ng/mL. Urinalysis was normal. Ultrasound showed an enlarged prostate with bladder wall thickening and moderate post-void residual, consistent with chronic outlet obstruction. Symptoms worsened despite escalating alpha-blocker therapy and a trial of ciprofloxacin. Given persistent concern for malignancy, a PSA was repeated 8 months later and had increased to 24.8 ng/mL. An MRI revealed a PI-RADS 5 lesion with gross extraprostatic extension, possible anterior rectal-wall invasion, and a left pubic ramus lesion; prostate volume measured 188g. Biopsy confirmed Grade Group 5 prostate adenocarcinoma. PSMA PET showed nodal disease and pelvic metastasis. Systemic therapy was initiated.

Discussion: This case demonstrates how malignancy can be overlooked when LUTS are attributed solely to BPH, especially in older men. A rapid rise in PSA, persistent symptoms, and early metastatic spread illustrate that aggressive disease can occur even later in life. Literature shows that symptom-guided PSA testing and selective MRI use can improve detection of high-grade cancers. Although routine screening beyond age 70 is debated, evidence suggests that men with good baseline functional status, like our patient, and new urinary symptoms may benefit from individualized assessment. This case aligns with emerging frameworks advocating targeted evaluation rather than age-based exclusion.

Conclusion: In older adults presenting with persistent LUTS, a rising PSA warrants timely investigation regardless of age. This case highlights the need for symptom-driven testing and supports using MRI-based risk stratification when clinical suspicion is high. Individualized assessment may prevent delayed diagnosis of aggressive disease in the geriatric population.

A56

Could it be PE? An Atypical Presentation of PE and PVT in an Older Adult.

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Introduction

Older adults exhibit atypical symptoms of venous thromboembolism (VTE). We describe a case with unusual combination of portal vein thrombosis (PVT) and pulmonary embolism (PE), presenting as sudden bilateral vision changes and bradycardia.

Case presentation

A 76-year-old man with hypertension, benign prostatic hyperplasia, and hypogonadism (on testosterone replacement therapy) presented with abdominal pain and sepsis. Laboratory tests revealed hyperbilirubinemia (total 5.6 mg/dl), acute kidney injury (Cr 3 mg/dl), transaminitis (AST 402 IU/l, ALT 289 IU/l), lipase >3,000 IU/l, and lactic acidosis 4.1 mmol/l. CT abdomen with possible malignancy versus cholangitis. MRCP with gallstones and mural thickening. Lap cholecystectomy on Day 4, requiring external drain to the gallbladder (GB) fossa due to friable cystic duct. Concern for bile leak led to ERCP on Day 7; biliary stent placement unsuccessful due to perianipullary diverticulum. MRI demonstrated fluid collection in GB fossa. On Day 9 patient developed sudden bilateral blurred vision, bradycardia, and hypertensive emergency. Workup demonstrated subsegmental PE and concomitant PVT. Intravenous heparin/antihypertensives started with vision and overall improvement. ERCP with biliary stent placement on Day 11, removed Day 14, repeat ERCP with no leak.

Discussion

The combination of PE and PVT is rare, and although each condition can be asymptomatic, presenting with vision changes and

bradycardia is even more unusual (1). Asymptomatic or minimally symptomatic VTE is seen in older adults, particularly with malignancy (2). In acute PE, the most common ECG findings include normal sinus rhythm/tachycardia and the classic S1Q3T3 pattern. Additionally, ~8% of older patients have new-onset atrial fibrillation with PE diagnosis (3).

Conclusion

VTE in older adults may present with non-respiratory symptoms such as acute vision changes and paradoxical bradycardia. Clinicians should maintain high index of suspicion when evaluating postoperative or septic older adults. Early recognition may reduce delays in diagnosis and treatment.

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A57

A Quiet Clue: Minor Weight Changes Signaling Major Disease

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Background: Unintentional weight loss (UWL) in older adults is defined as 5% or greater involuntary decline of body weight in 6-12 months. While most cases of UWL in older adults are from non-malignant or unknown etiologies, a third are caused by malignancy. Evaluation of UWL may be challenging in ambulatory settings due to many factors demonstrated in this case.

Case: Ms. M was an 88 year-old community-dwelling woman with a history of remote breast cancer treated with lumpectomy and radiation, tobacco use, and heart failure with preserved ejection fraction (HFpEF) who presented to geriatrics clinic to establish primary care. Weight trend revealed a 7-pound (6%) decrease over 10 months, which was attributed to aggressive diuresis for HFpEF. She screened negative for depression, dementia, and feeding issues. Over 6 months, she remained clinically stable but developed additional 5% UWL without associated symptoms. Bilateral mammogram was negative. Because other patient concerns took precedence, further evaluation for UWL was deferred. Due to persistent, slow UWL at follow-up 5 months later, evaluation was again recommended. However, she fell at home and was hospitalized before the assessment could occur. Imaging revealed diffuse metastatic disease of unknown primary. She opted for comfort-focused care and died in the hospital two days later.

Discussion: UWL can present insidiously and should be closely monitored at every ambulatory visit. For a frail older patient with low baseline weight, it is important to consider trend and proportion rather than gross weight changes. This patient had risk factors for malignancy warranting advanced imaging, though there were multiple barriers to pursuing diagnosis that may be common for outpatient providers. First, electronic medical records do not readily demonstrate weight trends, limiting detection of subtle, slow changes. In addition, HFpEF diuresis history and scale variance can confound interpretation of weight changes. Finally, urgency of evaluation may not be evident to patients or caregivers, and shared decision-making is essential to determine management. Earlier detection in this case may not have changed the outcome but may have afforded the patient opportunities to optimize her care and quality of life. This case illustrates the importance of accurate weight monitoring, as well as a systematic, collaborative approach to UWL evaluation and management in the ambulatory setting.

A58

Preserving Fragile Functional Stability in a 100-Year-Old: How Well-Intentioned Supports Can Destabilize Centenarian Longevity

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Background:

Very old adults may maintain a fragile but functional baseline, yet even modest external interventions—supplement therapies, multiple prescribers, or non-coordinated care—can destabilize this balance. This case shows how cumulative external inputs disrupted the functional stability of a 100-year-old woman and how simplification restored it.

Methods:

We conducted a retrospective review of all available records (outpatient, emergency department), cognitive assessments, and caregiver/volunteer logs. We cataloged medications, supplements, injections, provider interactions, and social supports. Domains evaluated included physical stability (mobility, BP control), cognition, emotional well-being, medication/supplement burden, adherence, and care fragmentation. Interventions focused on streamlining her regimen, consolidating medical oversight, and establishing consistent support routines.

Results:

At baseline, the patient ambulated independently with a cane, engaged socially and cognitively, and showed stable memory. During periods of increased external input, she developed episodic severe headaches, transient confusion, and blood-pressure lability. Contributing factors included >15 daily supplements, family-initiated testosterone therapy and B12 injections, multiple prescribers without coordination, intermittent non-adherence related to mild cognitive impairment, and anxiety about loss of independence. After simplification (removal of nonessential supplements/injections, unified care oversight, reinforced adherence supports), symptoms resolved, and her functional baseline remained stable.

Conclusions:

In exceptionally old patients, functional stability relies on a delicate equilibrium across physiologic, cognitive, social, and therapeutic domains. Well-intentioned but uncoordinated external inputs can inadvertently destabilize this balance. A whole-person, simplified, and coordinated care approach may prevent destabilization and help preserve functional longevity in centenarians.

External Inputs Contributing to Functional Destabilization

EXTERNAL INPUT	DESTABILIZING IMPACT
15 daily supplements	Blood pressure variability, headaches
B12 injections (unsupervised)	Sleep disruption, anxiety
Multiple prescribers / fragmented care	Non-coordinated plans, conflicting recommendations
Medication/supplement non-adherence	Labile symptoms, unpredictable exacerbations
Family-initiated therapies	Overtreatment, destabilization of baseline
Irregular support routines	Functional inconsistency, episodic decline
Testosterone therapy	Physiologic overstimulation → episodic headaches, BP lability

A59

Slipping Through the Cracks: Supporting an Unrepresented Older Adult with Hearing Loss through Cancer Diagnosis

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Background

AGS defines unrepresented older adults as patients who “(1) lack decisional capacity to provide informed consent for a particular medical treatment, (2) have not executed an advance directive that addresses the medical treatment at hand and lack capacity to do so, and (3) lack representation from a surrogate decision-maker (i.e., family, friend, or legally authorized surrogate).”¹ Hearing and memory impairments can

complicate these cases, sometimes leading clinicians to falsely assume an older adult is unrepresented.

Case Description

VD is a 73-year-old male admitted to the hospital from a long-term care facility with rectal bleeding and subsequently diagnosed with stage IV rectal carcinoma. He has major neurocognitive disorder and severe hearing loss, though there are no prior specialist appointments or formal testing related to either. Based on careful clinician assessment using available communication methods (pocket talker, white board, printed board), the patient is deemed to lack capacity for complex medical decision making, including whether to pursue cancer treatment. Initial efforts to locate a surrogate were unsuccessful; per the LTC facility, he has no family, friends, or surrogate decision makers. Concerned about his ability to navigate care after diagnosis, the team conducted a deeper EMR search using a structured algorithmic approach and ultimately located several estranged relatives. They were eager to reconnect, assumed the role of health advocates, and were warmly received by VD.

Conclusion

Unrepresented older adults with serious illness are profoundly vulnerable, especially when sensory and cognitive impairments hinder communication and autonomy. This case illustrates how assumptions of isolation can be misleading, and how persistence in searching for surrogates may uncover meaningful connections. As a profession, we hold an ethical obligation to make sustained, good-faith efforts to identify decision makers and ensure patients are not left to navigate complex, life-altering choices alone.

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A60

Integrating Geriatric Oncology Principles in the Management of a Frail Patient with Small Cell Lung Cancer

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Case:

A 74-year-old woman with a recent diagnosis of small cell lung cancer was admitted for shortness of breath and found to have pneumonia. At baseline, she was fully independent in her activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and lived with her husband. A CT scan of the chest, abdomen, and pelvis revealed multiple metastatic lesions. Despite appropriate antibiotic therapy, she continued to decline, ultimately requiring intubation and mechanical ventilation.

A goals-of-care discussion with her family introduced a comfort-focused approach and hospice care; however, the family shared that the patient would have wanted to pursue urgent chemotherapy. She began chemotherapy but developed delirium two days later. After further discussion, she was transitioned to comfort care and died shortly thereafter.

Teaching Points:

Lung cancer, the second most common malignancy in the United States, disproportionately affects older adults (OAs), with peak incidence between ages 65 and 75. **MULTICOMPLEXITY**, such as that seen in this patient with metastatic disease and frailty, places OAs at high risk for delirium and loss of decisional capacity. Early geriatric assessment (GA), including a discussion of **WHAT MATTERS MOST**, is essential to help older adults avoid complications, preserve independence, and maintain autonomy.

Discussion:

Over half of all cancers are diagnosed after age 65, and chemotherapy—urgent or not—may be appropriate across all age groups.

However, **MULTICOMPLEXITY** in previously independent OAs with advanced disease, frailty, and delirium can result in drastically different outcomes than in younger adults.

Recognizing this, the American Society of Clinical Oncology (ASCO) released guidelines in 2018 recommending GA prior to initiating cancer therapy, updated in 2023 to emphasize the assessment and management of vulnerabilities in OAs receiving chemotherapy. Tools developed by the Cancer and Aging Research Group (CARG), including the Practical Geriatric Assessment (PGA) and a chemotherapy toxicity risk calculator, address domains of the 5Ms linked to poor outcomes in older adults with cancer. Implementing GA using validated instruments such as the PGA and CARG tools may enhance decision-making and improve outcomes for older adults like this patient.

A61

Rapidly Progressive Dementia in a 73-year-old with Cerebral Amyloid Angiopathy

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BACKGROUND

Cognitive decline in older adults requires evaluation for reversible causes. Cerebral amyloid angiopathy (CAA) can accelerate decline. Distinguishing non-inflammatory CAA from potentially treatable CAA-related inflammation (CAA-RI) has therapeutic implications.

METHODS

We describe the case of a 73-year-old man with hypertension who experienced rapid cognitive and functional deterioration over six months. Data were obtained from clinical evaluation and neuroimaging.

RESULTS

A 73-year-old male with hypertension presented with worsened confusion and inability to engage in cognitive testing. Montreal Cognitive Assessment scores declined from 25/30 two years ago to 15/30 just seven months prior. His wife reported months of increased wandering and dependence for dressing, grooming, and bathing, with new frustration when offered assistance. She noted daily “sundowning,” increased daytime sleep, and earlier sleep–wake times. He remained physically robust, ambulatory, and continent, with no headaches, seizures, hallucinations, delusions, or loss of consciousness.

He was oriented only to self. MRI showed asymmetric microvascular white-matter changes (right > left) and numerous peripheral punctate susceptibility lesions consistent with CAA, with minimal atrophy and no infarct, mass, or vasogenic edema.

Given the rapid decline, geriatrics considered possible CAA-RI; however, neurology found this unlikely due to absence of inflammatory features or edema and felt the trajectory was most consistent with neurodegenerative dementia, likely Alzheimer’s with coexisting CAA plus or minus vascular pathology. Steroid therapy was deferred due to low expected benefit and high delirium risk. Extensive workup for infectious, metabolic, nutritional, autoimmune, iatrogenic, or inflammatory causes was unrevealing. The patient received supportive care and vascular risk-factor optimization.

CONCLUSIONS

In older adults with rapid cognitive decline and MRI evidence of CAA, differentiating non-inflammatory CAA from CAA-RI is essential, as CAA-RI can be reversible with steroid therapy. This case underscores the value of careful clinical–radiologic correlation and interdisciplinary assessment to avoid unnecessary iatrogenic risks while ensuring evaluation for reversible causes of dementia. Supportive management and risk-factor optimization remain central to management of neurodegenerative disease with coexisting CAA.

A62

Rapidly Progressive Dementia: A Case Report of Creutzfeldt-Jakob Disease

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Background: Creutzfeldt-Jakob disease (CJD) is a human prion disease characterized by a variety of neurodegenerative symptoms, including dementia. Diagnosis is often challenging because non-specific cognitive features can delay proper care.

Case presentation: A 77-year-old man was admitted for confusion, irritability, and agitation. Up until two months ago, he lived independently without difficulties. His past medical history was significant for diabetes mellitus, hypertension, major depressive disorder, papillary thyroid carcinoma status post left hemithyroidectomy, and prostate cancer status post prostatectomy. Two months ago, he began exhibiting progressive cognitive decline characterized by repetitive questioning, word-finding deficits, and difficulty managing medications. MOCA score was 15/30. Brain MRI revealed increased signal in the bilateral parietal cortical regions on diffusion-weighted imaging, consistent with “cortical ribboning. Cerebrospinal fluid analysis by real-time quaking-induced conversion assay confirmed elevated tau and 14-3-3 protein levels. Following initial hospitalization, the patient was referred to the geriatric and palliative care multidisciplinary clinic for further symptom management, goals-of-care discussions, and advance care planning. Subsequently, the family observed further progressive neurocognitive decline, accompanied by nocturnal myoclonic jerks. Within three months, he became bedbound and nonverbal, and the family was unable to care for him and had another hospitalization for status epilepticus. Further goals-of-care conversations with a multidisciplinary team (including a geriatrician, palliative care physician, neuropsychiatrist, neurologist, and social worker) led to enrollment in inpatient hospice.

Discussion: CJD is an important though rare part of the differential diagnosis for dementia in the elderly population. Management focuses mainly on prompt recognition, diagnosis, and supportive care, alleviating suffering, and controlling end-of-life symptoms. Due to the rapid progression of CJD, early disease detection enables timely implementation of advance care planning, exploration of patient’s goals regarding current and future medical care plans, optimization of symptom control, and reduction of caregiver burden. Prompt, open, and detailed communication among the provider, patient, and family can facilitate an appropriate hospice referral.

A63

Beyond Their Atypical Antipsychotic Medications. What are the Most Important Additional Cardiac Risk Factors in Nursing Home Patients Taking Them?

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Background:

Atypical antipsychotic medications are associated with increased risk of metabolic dysregulation and cardiovascular disease. Long-term use may contribute to weight gain, glucose intolerance, dyslipidemia, and subsequent development of diabetes, cardiovascular disease (CVD), atherosclerotic cardiovascular disease (ASCVD), and congestive heart failure (CHF). However, these risks are less well characterized among Veterans with mental health disorders residing in nursing home settings.

Methods:

A one-time, retrospective observational chart review was conducted among nursing home residents prescribed atypical antipsychotic medications for at least three months. Metabolic and clinical data—including weight, blood pressure, lipid profile, and blood glucose—were extracted from CPRS records without identifiable patient information. Baseline characteristics, psychiatric

diagnoses, metabolic comorbidities, and antipsychotic type were recorded. Ten-year risk estimates for CVD, ASCVD, and CHF were calculated using the American Heart Association PREVENT™ Online Calculator.

Results:

Atypical antipsychotic use, especially among individuals with schizophrenia and metabolic abnormalities, was the strongest nontraditional hazard associated with elevated CVD and CHF risk. Age and reduced renal function (low eGFR) further intensified CHF risk. BMI, HbA1c, and diabetes status were major predictors of both CVD and ASCVD. ASCVD risk showed the strongest associations with lipid abnormalities, particularly elevated total cholesterol and reduced HDL. CHF risk was most influenced by obesity, renal impairment, and chronic atypical antipsychotic exposure.

Conclusion:

Nursing home residents using atypical antipsychotics demonstrate elevated 10-year risks for CVD, ASCVD, and CHF. Targeting modifiable metabolic and cardiovascular risk factors may help reduce long-term morbidity in this high-risk population.

A64

Consideration of Valproic Acid for Hyperactive Delirium in Dementia

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Background

Delirium is an acute, fluctuating change in attention and cognition, which can be hypoactive, hyperactive, or mixed [1]. Antipsychotics can be seen as a “quick fix” for inpatient hyperactive delirium, but are recommended to be second-line after non-pharmacologic interventions due to multiple associated risks [2, 3]. A limitation to antipsychotic use is baseline QTc prolongation or concurrent use of QTc prolonging medications. Valproic acid has potential for hyperactive delirium management in these scenarios [4].

Case

A 93 year-old man with moderate dementia presented to our ER with right-sided weakness after an unwitnessed fall. A 5.0 cm intraparenchymal hemorrhage was found in his left parietal lobe. He was admitted to neurology. Hospitalization was complicated by ileus, dysphagia requiring NG tube, and C. difficile requiring a fecal management system. The geriatrics consult service was engaged on hospital day 24 for management of hyperactive delirium with QTc intermittently >500ms. The neurology team was interested in our opinion on valproic acid for his symptoms. Upon further review, the patient's care was never halted or impacted by the reported agitation. Housestaff and nursing confirmed the behaviors in question were moaning, tachypnea, and general distress. We recommended recreational therapy for delirium and to focus on pain control, secretion management, limiting tubes/lines, and continuing goals of care discussions for his overall poor prognosis.

Conclusions

This case was an opportunity to evaluate the data behind valproic acid for hyperactive delirium, which is largely mixed [4]. It was also a reminder to investigate what is being defined as “agitation” to ensure that pharmacologic interventions are being used meaningfully.

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A65

Room Tilt Illusion and Episodic Falling in an Older Adult: A Case of Otolithic Dysfunction in Recurrent BPPV

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Background

Atypical sensory disturbances, such as episodic falling sensations and altered verticality perception, pose diagnostic challenges in older adults because they can mimic central neurological disease. Rare phenomena like room tilt illusion may arise from peripheral vestibular dysfunction, particularly otolith organ impairment, which senses linear acceleration and head position. This case highlights otolith dysfunction in recurrent benign paroxysmal positional vertigo (BPPV), underscoring the importance of careful differential diagnosis.

Case

A 91-year-old male with atrial fibrillation, hypertension, heart failure, and recurrent BPPV developed acute fear of falling and distorted proprioception after a respiratory infection. He described the bed disappearing beneath him and a room tilt illusion with 90° rotation of objects, without vertigo, weakness, or focal deficits. CT head excluded stroke and hemorrhage; cervical spine imaging showed severe C6-C7 stenosis, deemed noncontributory. Epley maneuver, meclizine, and positional changes gave transient relief. Outpatient neurology confirmed persistent symptoms interfering with therapy at a nursing home lacking vestibular services. Recommendations included vestibular testing, symptom logging, increased activity, discontinuation of meclizine, and referral to vestibular therapy and neurotology.

Discussion

Symptoms were attributed to recurrent BPPV with probable otolith dysfunction, as falling sensations without spinning implicated otolith organs. Room tilt illusion likely reflected impaired integration of vestibular, visual, and somatosensory inputs. Literature suggests this rare disturbance is usually benign, linked to BPPV, Ménière's disease, or vestibular migraine.

Conclusion

This case illustrates the complexity of diagnosing room tilt illusion in older adults. Though benign, peripheral vestibular dysfunction required extensive evaluation to exclude cerebrovascular disease. For this previously independent patient, symptoms were profoundly disabling, limiting therapy adherence. Multidisciplinary management, vestibular testing, and neurotology referral proved essential. Ineffective treatments like meclizine were discontinued. Targeted vestibular care remains crucial in reducing fall risk and restoring function.

A66

Rivastigmine Rapidly Resolves REM Sleep Behavior Disorder and Neuropsychiatric Symptoms in Parkinsonism.

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Background

Neuropsychiatric complications are challenging in elderly patients with Parkinson's disease and dementia with behavioral and psychological symptoms (BPSD). Randomized trials support Rivastigmine, a dual acetylcholinesterase and butyrylcholinesterase inhibitor, to improve cognition, attention, and behavior in Parkinson's disease dementia (PDD) and Lewy body dementia (DLB).

Case

An 83-year-old male with Parkinson's disease, dementia with BPSD, controlled depression, and BPH post-TURP with frequent

UTIs presented from rehab with severe agitation, visual hallucinations, and dream enactment suggestive of REM sleep behavior disorder. He had multiple hospitalizations, rehab transitions, and geriatric psychiatry follow-up. In the ED, he received empirical treatment for possible urosepsis and catheter replacement. A multidisciplinary team (neurology, psychiatry, geriatrics) ruled out toxic-metabolic causes and suspected DLB or atypical Parkinson's disease. His regimen was reassessed: evening quetiapine increased, rivastigmine 4.6 mg patch started, plus nonpharmacological interventions (structured sleep, environmental changes, caregiver education). Within 24 hours, rivastigmine resolved hallucinations and vivid dreams, with improved alertness, attention, and executive function. Quetiapine and nonpharmacological strategies reduced agitation, eliminating the need for 1:1 monitoring.

Discussion

Rivastigmine rapidly resolved RBD and neuropsychiatric symptoms, likely due to dual cholinesterase inhibition, which improves memory, executive function, and gait stability while reducing falls. Combining rivastigmine with quetiapine and nonpharmacological strategies underscored the value of multimodal therapy in geriatric neuropsychiatric care.

Conclusion

Rivastigmine offers a promising approach for managing RBD and neuropsychiatric symptoms in suspected DLB or PDD. Integrated with antipsychotic adjustments and nonpharmacological interventions, it supports cognitive and behavioral improvements. Further research should evaluate long-term efficacy, with multidisciplinary follow-up essential to optimize outcomes.

A67

Beyond Glycemic Control: A Rare Presentation of Empagliflozin-Related Polycythemia

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Background:

Empagliflozin, a SGLT2 inhibitor, is widely used in the management of type 2 diabetes mellitus, chronic kidney disease, and heart failure. It acts by inhibiting renal glucose reabsorption and is known to improve glycemic control, slow kidney disease progression, and reduce heart failure-related hospitalizations and mortality. While urinary tract and genital infections are well-recognized adverse effects, data regarding empagliflozin-associated polycythemia remain limited. We report a case of erythrocytosis following initiation of empagliflozin.

Methods:

A 68-year-old man presented for routine evaluation and was incidentally found to have elevated hemoglobin and hematocrit levels. He was asymptomatic and denied pruritus, paresthesia, sleep disturbances, or tobacco use. Empagliflozin had been initiated one year earlier for the management of heart failure with preserved ejection fraction due to cardiac amyloidosis. His hemoglobin peaked at 18.5–18.9 g/dL with a hematocrit of 55.3–56.6%.

Results:

Evaluation revealed normal renal function, iron studies, and erythropoietin levels. Polycythemia vera was excluded with negative JAK2 V617F and JAK2 exon 12–15 testing. The patient was started on low-dose aspirin and phlebotomy due to hematocrit >50%. Empagliflozin was discontinued for one month, after which his hemoglobin and hematocrit decreased to 15.5 g/dL and 44.7%, respectively. Existing literature suggests SGLT2 inhibitors may enhance erythropoiesis by increasing erythropoietin production and lowering hepcidin levels, thereby promoting iron mobilization. Ongoing studies aim to further characterize this erythrocytogenic effect.

Conclusion:

We describe a rare case of Empagliflozin-associated erythrocytosis that resolved upon medication withdrawal. This observation highlights the need for heightened clinical awareness and further investigation into the long-term hematologic effects and clinical significance of SGLT2 inhibitor-induced erythrocytosis.

A68

Blood, Brain, and Bias: Navigating Intracranial Hemorrhage in an Aging Brain

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Background: Therapeutic inertia is often observed among older adults such as with the hesitancy to intensify antihypertensive medications with uncontrolled hypertension. Age-related bias can also lead to delayed evaluation and diagnoses.

Case: 84-year-old male with history of atrial fibrillation (on rivaroxaban), hypertension, stroke who presents after unwitnessed fall. On arrival, patient is A&O x 4. He has a facial droop, dysarthria, and decreased strength in his right upper extremity, all baseline from his prior stroke. He was at baseline independent in all ADLs and ambulated with a walker.

Patient was found to have an acute right subdural hemorrhage (SDH) without midline shift. Subsequent scans showed increasing size of SDH and an additional subarachnoid hemorrhage. Patient required reversal agents for rivaroxaban but his SDH continued to expand. Patient had been undergoing outpatient hematologic workup for an elevated WBC to 100K/mm³ over 2 months. Neurosurgery noted that patient was not a candidate for surgical intervention but did not clearly state reasoning though may have been due to age, possible coagulopathy, and neurological exam being at baseline. Patient's SDH eventually stabilized at 4.5 cm by day 3 but gradually developed increased confusion over the next 5 days, to only A&O x 1. This was complicated by receiving lorazepam 0.5mg and haloperidol 8mg for an MRI of his hip to characterize his hip fracture. Patient's confusion was attributed to hospital-acquired delirium due to sedative use and old age; contribution of the SDH was not discussed and management for SDH was never revisited. With continued decline in cognition, family opted for comfort care and patient passed away on day 14 of hospitalization.

Discussion: The initial decision against surgical intervention was made while his neurological exam was at baseline. The subsequent worsening of cognition was attributed to geriatric delirium rather than revisiting whether the change was a delayed manifestation of his SDH and reassessing the need for evacuation. Although we cannot ascertain whether his course would have been different, this case highlights the importance of revisiting therapeutic decisions and being cognizant of reversible causes of delirium beyond risks as a hospitalized older adult.

A69

When "Home" Goes Smoke-Free: A Patient-Centered Motivational Interviewing Approach to Policy Implementation in VA LTC

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Background: The VA instituted a system-wide smoke-free policy in 2019–2020, but implementation in nursing homes is challenging because long-term care functions as Veterans' homes, and smoking is closely tied to autonomy, identity, and social connection. Veterans also have high tobacco use and homelessness risk. Strict enforcement may strain rapport, create ethical dilemmas, or precipitate relapse. This case series describes a physician-led motivational interviewing (MI) strategy to support adherence by aligning policy requirements with Veterans' goals.

Methods:

Three Veterans in a VA nursing home were engaged using structured physician-directed MI. Sessions explored smoking motives, risk perception, psychosocial needs, and preferred goals to inform individualized care planning.

Results:

Case 1: A 75-year-old man with lifelong smoking, homelessness history, and polysubstance use viewed smoking as a personal right and declined cessation. MI revealed acknowledgement of fire risk and preference for structured outdoor space. He continues MI and group-cessation encouragement while an off-campus option is explored.

Case 2: A 65-year-old man with stage IIIa lung cancer walked off campus to smoke and lacked motivation to quit despite understanding risks. After treatment completion and preference misalignment with facility rules, he is transitioning to assisted living that allows smoking. He continues MI and cessation pharmacotherapy trials.

Case 3: An 86-year-old long-term resident smoked to cope with loneliness and boredom. MI identified unmet needs related to isolation and loss of peer networks. Targeted social programming was initiated, and scheduled therapeutic leave is under consideration to reduce distress-driven triggers.

Conclusion:

A structured MI approach may support patient-centered adaptation to smoke-free policies by addressing identity, autonomy, and psychosocial drivers while preserving therapeutic alliance. MI also has potential as a shared decision-making tool in older adults; however, its utility may be limited in individuals with moderate to severe dementia, highlighting the need for adapted communication strategies. Facilities may benefit from standardized MI, pre-admission smoking agreements, and exploration of alternative designated spaces while balancing safety, autonomy, and heightened risks such as homelessness and cognitive impairment.

A70

Subtle Signs, Strategic Decisions: Collaborative Risk-Balancing in Atypical NPH

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Background: Normal pressure hydrocephalus (NPH) is rare, with an estimated prevalence of 10–22 per 100,000¹. Classic features include gait disturbance, cognitive decline, and urinary incontinence. Early treatment within 3–9.5 months improves outcomes. Diagnosis often involves high-volume CSF removal via lumbar puncture or lumbar drainage, followed by TUG and MoCA assessments. This case highlights a high-functioning older adult with incidental ventriculomegaly and minimal symptoms, emphasizing collaborative decision-making when procedural risks must be weighed against low symptom burden.

Case: A 78-year-old man with dyslexia, diabetes with neuropathy, urinary frequency, and ambulates with a cane had been followed in geriatrics since 2018. Despite limited education, he managed two restaurants, worked as an art curator, and resumed international travel. He reported falls in 2023; MoCA scores were 21/30 (2023) and 14/30 (2024), likely affected by dyslexia.

In February 2025, he presented to the ED with brief dysphasia. Neurologic exam and CTA were normal; CT showed ventriculomegaly out of proportion to atrophy. Tandem gait mildly impaired; no magnetic gait or urinary changes. Neurology recommended outpatient monitoring. At post-ED geriatric visit, he remained independent. Maintaining cognition and mobility to continue traveling was his priority. After a goals-of-care discussion, further evaluation was recommended.

In September 2025, subtle shuffling gait was noted; MRI showed moderate ventriculomegaly (Evans index >0.3) without sulcal effacement. He underwent a 3-day lumbar drain trial (20 mL q2h). Baseline MoCA 17/30, TUG 12.38s, cognitive TUG 24.81s (dual-task cost 100%). By day 3, TUG 12.9s; cognitive TUG 14.8s (dual-task cost

14.7%). Shunt placement was deferred. Follow-up showed slight gait improvement; cognition unchanged.

Conclusion: This case illustrates atypical NPH in older adults, where subtle features may be masked by comorbidities. The team navigated a risk-benefit dilemma, balancing low symptom burden against invasive evaluation. A geriatric-led, patient-centered approach prioritized the patient's goal of maintaining cognition and mobility, guiding further evaluation. Collaborative decision-making and careful risk assessment are essential in atypical presentations.

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A71

“Flight of the Mind”: A Rare Case of Altered Mental Status due to Psittacosis Meningoencephalitis

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BACKGROUND: Psittacosis is a zoonotic infection caused by *Chlamydia psittaci*, transmitted through exposure to infected birds. The diagnosis remains challenging due to its nonspecific clinical syndrome, typically manifesting as atypical pneumonia. Herein we present a case of altered mental status due to severe meningoencephalitis, as the initial presentation of psittacosis infection.

CASE DESCRIPTION: A 78-year-old South-Asian man, with non-insulin dependent type 2 diabetes, presented with acute altered mental status. On arrival, he was febrile, hypertensive, aphasic, then later became obtunded. He was emergently intubated for airway protection and admitted to ICU. CT head and MRI brain ruled out stroke. Extensive infectious (bacterial, viral and fungal), autoimmune and seizure work up was negative. A lumbar puncture was performed and CSF showed elevated protein and lymphocytic pleocytosis, consistent with aseptic meningitis. His family reported heavy domestic pigeon exposure. Given this history and lack of alternative causes, psittacosis meningoencephalitis was suspected. The patient was started on a course of minocycline for *C. psittaci* infection. His neurologic status improved gradually with supportive and targeted therapy.

DISCUSSION: Psittacosis, caused by *Chlamydia psittaci*, is often underreported and empirically treated. It is important to have a high clinical suspicion for psittacosis in patients with significant avian contact history; meningitis is a rare initial presentation. Culture and gene probe techniques for *C. psittaci* are not available for routine clinical use, which makes the diagnosis difficult. Brain imaging is usually non-revealing. CSF testing can show elevated protein and lymphocytic pleocytosis. Clinical mNGS can be used when available. Tetracyclines remain the therapeutic agent of choice.

CONCLUSION: Psittacosis should be considered in the differential diagnosis of altered mental status and aseptic meningitis, when bird exposure is present and standard studies are unrevealing.

A72

Hypercalcemia induced functional decline in an older adult: A Geriatric Syndrome manifestation of primary hyperparathyroidism

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Background

Hypercalcemia is a common metabolic abnormality in older adults. In geriatric populations, hypercalcemia can present atypically with weakness, falls, delirium or functional decline rather than overt metabolic symptoms. Recognizing these nonspecific presentations is essential as they often overlap with other geriatric syndromes such as immobility, frailty, and deconditioning.

Case Description

An 87-year-old woman with heart failure, hypertension, hyperlipidemia, type II diabetes, was initially hospitalized for a CHF exacerbation. Following treatment for heart failure, she was discharged to a SAR due to deconditioning. During her SAR stay, the medical team noted worsening hypercalcemia and lack of progress in physical therapy prompting transfer back to the hospital. She had been aware of her hypercalcemia for 2–3 years, with her primary care doctor monitoring labs during this period. On presentation, she was hemodynamically stable with corrected calcium 14.3 mg/dL, ionized calcium 1.56 mmol/L, and creatinine 1.16 mg/dL.

Endocrinology initiated intravenous hydration, zoledronic acid, and cinacalcet. Calcium improved but remained mildly elevated. Cinacalcet was titrated to 60 mg twice daily. The patient declined surgical parathyroidectomy, and further imaging was deferred.

During treatment, mild volume overload developed, managed with short course IV furosemide, then transitioned to oral furosemide 40 mg daily.

After calcium correction and electrolyte repletion, the patient demonstrated functional improvement, returning to SAR where she progressed further in therapy, surpassing what had become her functional baseline over the past 2–3 years.

Discussion

This case illustrates hypercalcemia as a reversible cause of geriatric functional decline, often mistaken for progressive frailty or deconditioning. In the frail elderly, nonspecific symptoms such as decreased ambulation, confusion, or failure to thrive may represent underlying metabolic derangements rather than primary neuromuscular disease or deconditioning. Management in this population requires careful balance between aggressive correction of hypercalcemia and avoidance of volume overload or renal injury. Additionally, the decision to avoid parathyroidectomy highlights the importance of shared decision making and a cautious approach.

A73

Seize the Robaxin: A Case of Methocarbamol-induced Seizure in a Septuagenarian

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Background

Methocarbamol is a centrally acting skeletal muscle relaxant used since 1957. It suppresses the central nervous system, which can lead to serious risks such as bradycardia, hypotension, falls, sedation, and seizures. While seizure occurrence is rare with limited evidence, methocarbamol is generally avoided in older adults due to its anticholinergic activity. We present a case of methocarbamol-induced seizure.

Case

A 70-year-old man with hypertension, hyperlipidemia, gastroesophageal reflux disease, Crohn's disease, and chronic ileocolic stricture with an anastomotic ulcer was admitted for elective right total hip arthroplasty. His postoperative course was complicated by ileus, which required ileocolic resection with an end ileostomy. One week into recovery, he was found unresponsive. Code stroke was called, and he received three doses of naloxone without effect. While in CT, he awakened and began responding to questions. He showed confusion that improved within 15 to 20 minutes. Neurologic and motor examinations were reassuring. CT, MRI, and EEG tests were all negative for acute abnormalities. The episode was considered a first-time seizure, as opioid overdose was ruled out due to lack of response to naloxone. The seizure was initially thought to be caused by recent surgery, anesthesia, or infection. Infection was ruled out with routine urinalysis and negative blood cultures. It was concluded that the seizure was triggered by methocarbamol toxicity after medication review. Since it was a provoked seizure without recurrence, there was no need for antiepileptics, and the patient was discharged with outpatient neurology follow-up.

Discussion

Clinicians should prescribe methocarbamol cautiously to older patients. Seizures are a rare side effect of methocarbamol; however, the risk increases in older adults. This case emphasizes the importance of reviewing medication side effects and adopting an interdisciplinary approach to the care of older adults. Further research is needed to determine the risk of methocarbamol-induced seizures in older adults with therapeutic dosing.

A74

Frailty as a Guide for Care of an Older Adult with Cardiac Implantable Electronic Device Endocarditis

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Introduction

Frailty, a state of diminished physiological reserve and increased vulnerability to stressors, complicates presentations of common medical conditions in older adults, predisposing them to poor outcomes (1). Cardiac implantable electronic device (CIED) endocarditis is rare. The diagnosis is made by blood cultures with a typical organism, such as *streptococcus* bacteria, and vegetations on device leads or heart valves. Treatment emphasizes device removal and an extended antibiotic course. Patients with advanced frailty may require alternative management strategies.

Case Description

A 97-year-old male resident of a memory care facility with multi-domain advanced frailty and a Comprehensive Geriatrics Assessment Frailty Index score of 0.766 (2) was brought to the hospital after being found unresponsive for an unknown time. He had moderately severe mixed Alzheimer's and Vascular Dementia and Sick Sinus Syndrome with dual chamber pacemaker in place. On admission he had hypothermia, hypernatremia, and 4/4 blood culture bottles positive for *streptococcus salivarius*. An echocardiogram confirmed a 0.5 cm mass on a pacer lead, consistent with CIED endocarditis. Guided by his advanced frailty, the electrophysiology team recommended against high-risk device extraction. Treatment with ceftriaxone for six weeks, followed by lifelong suppression with amoxicillin was initiated. The patient was discharged to a nursing facility for antibiotic treatment and rehabilitation.

Discussion

Frailty greatly impacts the care provided to acutely ill hospitalized older adults by aiding in prognostication and supporting mitigation strategies to decrease complications and poor outcomes. CIED endocarditis can be challenging to diagnose and its association with frailty further increases the rates of in-hospital mortality, neurological complications, and readmission rates. Care for these patients should focus on incorporating strategies that allow for individualized risk assessment, enable clinicians to align with patient goals, anticipate functional decline, and guide timely serious illness conversations.

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A75

Diagnosing Adult T-cell Leukemia-Lymphoma in Long-Term Care: An Interdisciplinary Approach

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Background: Adult T-cell leukemia-lymphoma (ATLL) is a rare malignancy driven by chronic infection with human T-lymphotropic virus, type 1 (HTLV-1). The incidence of ATLL is 0.06 in 100,000 in the United States with a median age of diagnosis in the 60s. 1

Case: 71 year-old, Haitian, bedbound woman in a nursing home with HTLV1-related myelopathy and neuropathy presented with generalized pruritic, violaceous, polymorphic plaques. Nursing staff promptly notified the Geriatric provider, who initiated a dermatology e-consult, leading to same-week skin biopsies. While awaiting results, the Geriatric provider, in collaboration with dermatology, ordered a Rapid Plasma Reagin test and excluded secondary syphilis. Histopathology revealed infiltrating T cells, highly suggestive of ATLL, and the patient was referred to oncology. She subsequently developed a painful, generalized, vesicular rash over her body and right face, involving the periorbital area, prompting evaluation in the emergency department. With biopsy findings and clear documentation of recent symptoms, the inpatient dermatologist rapidly diagnosed disseminated varicella-zoster virus infection, a known complication in patients with ATLL. Within 3 weeks of initial presentation, the diagnosis of ATLL was confirmed, and radiographic staging was completed in collaboration with oncology.

Discussion/Conclusion: Rare malignancies such as ATLL are challenging to diagnose in long-term care due to their atypical clinical manifestations, compounded by organizational barriers, including breakdowns of nurse-provider communication, limited access to specialty services, and fragmentation of care. In this case, geriatric providers played a central role in coordinating care and mobilizing resources across multiple care sites. Timely diagnosis was facilitated by effective nursing communication, rapid access to specialty care via e-consults, and close multispecialty collaboration spanning outpatient, inpatient, and long-term care settings. Multidisciplinary collaboration and clear lines of communication are essential in timely diagnosis of rare cancers in medically complex older adults in long-term care.

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A76

Late-onset mania in a patient with cerebrovascular disease, frontotemporal lobe degeneration, and history of depression: a review of diagnostic challenges in older adults

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Introduction: The cause of new onset mania is difficult to diagnose in older adults. Symptoms of executive and social disinhibition are often shared hallmark features of behavior variants of frontotemporal dementia (bvFTD), Alzheimer's with behavioral and psychological symptoms of dementia, and delirium, among other etiologies. Diagnosis can be especially challenging in patients with known cerebrovascular disease. In this case report, we review the diagnostic nuance of an older adult with known medical comorbidities presenting with new onset of mania. **Case Report:** A man in his mid-70s is evaluated for mania. He has a history of hypertension, remote right posterior cerebral artery (PCA) stroke, post-stroke depression in remission, and remote prostate cancer. Physical exam and laboratory studies were unremarkable. MRI Brain showed chronic microvascular ischemic disease and sequelae of previous PCA infarct. FDG-PET scan subsequently revealed extensive mild hypometabolism of the right temporal cortex, suggestive of a neurodegenerative process such as occurs in temporal-predominant FTD. Neuropsychological testing and further Neurology evaluation confirmed MCI alongside probable FTD and vascular changes. The patient showed clinical improvement through support from the Guiding an Improved Dementia Experience (GUIDE) program. **Discussion:** This case highlights the challenge in evaluating hypomania and mania onset in older adults. Older adults face inherent challenges in FTD diagnosis and often do not have imaging evidence of isolated severe frontal and temporal lobe atrophy compared to patients with earlier FTLT onset. Coexisting cerebrovascular disease often lead to erroneous exclusion of bvFTD diagnoses. Importantly, medical literature tends to exclude patients with

prior stroke and imaging evidence of cerebral vascular disease in FTD studies, further limiting our understanding of FTLT in older adults.

Conclusion: Older adults often have concurrent medical comorbidities that pose diagnostic challenges. Neuropsychological testing and a careful review of the clinical trajectory is essential for diagnostic accuracy. Timely recognition of mixed vascular neurodegenerative syndromes may help clinicians improve supportive interventions and optimize long-term outcomes.

A77

Pressure Injury is a Catastrophic Consequences of Being "Found Down"

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Background:

Pressure injury is a catastrophic consequence of being found down after a prolonged period of immobility. Age-related factors such as fragile skin, reduced mobility, balance impairment and muscle weakness increase the risks of falling and severe tissue injury. When pressure over bony prominences is sustained, skin and soft tissue damage may result in wounds that are difficult to heal. These wounds, especially Deep Tissue Pressure Injuries (DTPI), are easily overlooked in individuals with darker skin tones. DTPI may mimic bruising or hematoma, making diagnosis challenging. Accurate identification requires close attention to areas of pressure exposure, as visual inspection alone may underestimate the extent of damage. We report the case of an older African American woman who developed multiple DTPI after a fall.

Case:

An 84 yo woman was admitted following a fall at home. She was using a commode that broke, causing a fall to the floor where she lay for 3 days until discovered by her sister. On examination, skin injuries were noted on left heel and elbow, and ecchymosis on the left lateral thigh, with no signs of infection. The wounds were managed with saline cleansing, barrier film, and offloading. The left heel injury was treated with betadine and offloaded using heel protector boots, while the left elbow wound was covered with petrolatum impregnated gauze.

After one week, she was discharged to a rehabilitation facility, where wound reevaluation revealed unstageable pressure injuries on the left heel, thigh, and elbow, all covered with hard eschar. Debridement of the left elbow wound revealed a deep abscess requiring incision and drainage that released 50 cc of pus. The heel wound required sharp debridement and uncovered a Stage 3 pressure injury. The thigh wound evolved into a deep necrotic eschar; multiple debridements revealed a deep Stage 4 pressure injury. The heel and elbow healed in 3 weeks, but the thigh wound required multiple excisional debridements and negative pressure wound therapy (NPWT). After 3 months, she is bedbound and still receiving NPWT.

Conclusions:

Skin assessment is an important skill for primary care providers, particularly in patients with dark skin. Clinicians must maintain high suspicion for pressure injury in patients who are "found down," which is a major risk factor. Early identification, timely intervention, and comprehensive post-fall assessment are essential to prevent complications and improve outcomes.

A78

Balancing the Electrolyte Balance: Multifactorial Hyponatremia and Hyperkalemia in an Older Adult

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Background:

Electrolyte disorders are common in older adults, with an estimated 15 % having at least one abnormality at any given time. Age-related renal and hormonal changes, polypharmacy, and limited access to lab monitoring increase vulnerability. Even mild sodium or

potassium disturbances contribute to falls, confusion, and hospitalization. Recognizing the multifactorial nature of these imbalances is essential for safe management.

Case:

A 78 yo woman with hypertension managed with olmesartan, anxiety, and osteoarthritis presented for routine follow-up. She had prior history of hyperkalemia attributed to olmesartan, which resolved with potassium restriction. She was asymptomatic, but labs revealed recurrent hyperkalemia (serum potassium 5.9 mmol/L). Clinicians advised resuming potassium restriction and discontinuing olmesartan, with close follow-up.

At follow-up, patient was anxious, reported a metallic taste, and concerned about kidney injury. She disclosed use of ibuprofen 400 mg three times daily to manage foot pain. She was advised to discontinue NSAIDs. Labs showed improvement in hyperkalemia (serum potassium 5.0 mmol/L) but revealed significant hyponatremia (serum sodium 123 mmol/L, a 10 mmol/L decrease from initial visit). She was advised to seek urgent medical attention.

The following day, she went to the emergency department and reported fatigue, anxiety, and drinking 4L of water daily since learning of her hyperkalemia. Her serum sodium was 124 mmol/L, potassium 4.4 mmol/L, chloride 90 mmol/L, creatinine 0.95 mg/dL (baseline), glucose 104 mg/dL, low serum osmolality (261 mOsm/kg), urine sodium <20 mmol/L, and urine osmolality 221 mOsm/kg. She was admitted for management of hyponatremia due to primary polydipsia. Fluid restriction to 2 L daily increased sodium to 130 mmol/L. She was discharged with instructions to maintain 2L fluid intake daily. Follow-up labs showed sodium improved to 134 mmol/L and normal potassium.

Conclusions:

Overlapping factors including hypertension therapy, NSAID use, anxiety and excessive water intake led to recurrent hyperkalemia followed by symptomatic hyponatremia in an older woman. The case emphasizes importance of proactive electrolyte monitoring, medication review, and patient education to prevent cascading complications in community-dwelling older adults.

A79

Expanding the Search for Reversible Causes of Anemia in Older Adults: A Case Study of Pernicious Anemia

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Introduction

Anemia is common among older adults, often attributable to nutritional deficiency or chronic disease. “Unexplained anemia of aging” also constitutes a high proportion of anemia diagnoses in older people; while a diagnosis of exclusion, many studies do not include workup for pernicious anemia as a standard. (Jack Guralnik, 2022) Pernicious anemia may be overlooked as a cause of anemia, despite being treatable and more prevalent in the older adult population than younger cohorts. Reasons for this may be secondary to its insidious and nonspecific presentation, co-occurrence with other causes, or knowledge gaps in diagnosing/treating anemia in older adults among primary care physicians (Amrita Desai, 2019).

Case Presentation

An 82 y.o. community-dwelling woman with hypertension, vitamin D deficiency, and anxiety presented to the ED with progressive, generalized weakness. No history of gastric surgery or acid-suppression. She followed a balanced vegetarian diet, yet presented as cachectic (BMI 15.7) with hypotension and tachycardia, physical with dry mucous membranes and pallor. Hemoglobin was 5.8 g/dL, MCV 146 fL. Fecal blood negative, vitamin B12 <200 pg/mL, folate normal. An anti-intrinsic factor antibody test was positive, confirming pernicious anemia. She received a blood transfusion and began intramuscular vitamin B12, with improvement in counts. Due to profound deconditioning she needed a skilled

nursing facility, where ongoing intramuscular B12 and physical therapy facilitated recovery and eventual discharge back to the community.

Discussion

This case underscores the importance of maintaining a high index of suspicion for reversible causes of anemia in older adults, including pernicious anemia, particularly when initial tests are non-revealing. Prompt testing with anti-intrinsic factor antibody testing and parenteral vitamin B12 replacement have the potential to save patients from irreversible neurologic impairment and profound deconditioning.

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A80

Drug-Induced Vocal Cord Paralysis

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Background: Older adults are at increased risk for adverse drug reactions (ADR) likely due to age-related physiological changes, polypharmacy, and multimorbidity. Aging often leads to reduced renal clearance, which impairs drug metabolism. **Case Description:** A 79-year-old cognitively intact, community-dwelling, and independent woman with hypertension, heart failure, and stage 3a diabetic nephropathy presented with new-onset hoarseness and facial rash following a recent dosage increase of hydralazine, which she had been taking for several months for hypertensive heart disease. The otolaryngology team was consulted due to persistent hoarseness, and laryngoscopy revealed bilateral vocal cord paralysis. An inpatient rheumatology panel confirmed the diagnosis of drug-induced lupus. Her symptoms persisted despite discontinuation of hydralazine. Guided by what matters most to her at that time—to preserve life—a prophylactic tracheostomy was performed due to concern for impending respiratory failure. The prolonged hospitalization led to impaired mobility which further delayed her recovery. She was subsequently transferred to a skilled nursing facility for rehabilitative therapy, and her tracheostomy was successfully reversed a few months later. **Discussion:** The extracellular signal-regulated kinase (ERK) pathway supports cell survival and DNA repair. The increased risk of ADR from hydralazine in older adults arises from its inhibitory effects on the ERK pathway, which lead to cell death and trigger autoimmune responses that can cause drug-induced lupus. Vocal cord paralysis is a rare but recognized complication of lupus, resulting from widespread inflammatory damage to blood vessels and nerves. This complication can have devastating consequences in older adults, including prolonged hospitalization, impaired mobility, and ultimately, loss of independence. Moreover, the multicomplicity of this patient’s condition—particularly her existing nephropathy—further increased her risk of hydralazine-induced lupus due to reduced medication clearance and elevated drug concentrations in the bloodstream. While the precise mechanisms underlying heightened susceptibility to ADR in older adults remain unclear, emerging insights from geroscience may help explain why this population is disproportionately vulnerable.

A81

A New Model for Fall Risk Reduction in the Primary Care Setting

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Introduction

Falls screening, while well established, is under-utilized for effective falls prevention at senior health clinics. Our healthcare system adequately screens for falls but does not offer any follow-up once someone has been identified as having a fall. Patients of our geriatric primary care clinic have a high risk of falling and associated morbidity and mortality, highlighting a critical gap. Prior literature highlights unsuccessful efforts to address this problem via multidisciplinary clinics, particularly due to financial or staffing constraints. Recognizing the importance of this intervention, our study evaluates the feasibility and efficacy of a fall prevention clinic in our primary care clinic.

Methods

All patients ≥ 70 years with a fall in the previous year were consented via phone calls for participation in a falls screening visit with a multidisciplinary assessment (PT, PharmD, MD) and optional local balance classes. Secondary functional measures were collected to assess efficacy as well as a DEXA scan to evaluate bone health. Data analysis consisted of descriptive statistics, Fisher's exact test, Kruskal-Wallis test, correlation testing, and thematic analysis for qualitative data.

Results

Our data showed that we billed at a level 4 (CPT 99214) 66.66% of the time in our falls clinic compared to 64.58% of the time in our providers normal primary care clinic demonstrating comparable billing revenue. Interviews conducted with clinic staff found the clinic to operate smoothly and was found to be viable for continuation. There was a positive adherence to exercises with frequency of exercise being > 2 -3 times a week with 20/23 (87%), 12/18 (89%), and 14/16 (88%) patients following their exercise recommendations on the first, second, and third follow-up respectively.

Summary

Our findings may inform future interventions in falls reduction via multidisciplinary clinics. There is a need for a feasible and practical approach to address fall risk with appropriate follow-ups and dedicated clinical assessment. Our success can be attributed to the multidisciplinary incorporation of various specialties working towards a common goal. Comparable billing frequencies supported the feasibility of our program, allowing us to expand it further for future use. Our study highlights a replicable plan that allows us to support the community.

A82

Laying the Foundation for Age-Friendly Stroke Care Across a Health System

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Introduction: The Age-Friendly Health System (AFHS) 4Ms Framework—What Matters, Medication, Mentation, Mobility—provides a structured approach to optimize care for older adults. Integrating 4Ms into stroke care may promote goal-concordant care and reduce complications. This initiative assessed baseline awareness of the 4Ms among clinicians caring for patients with stroke in an academic health system to inform future educational strategy.

Methods: A needs assessment survey was distributed to clinicians in stroke units and emergency departments at 6 hospitals, including 3 recognized by IHI as AFHS. We evaluated awareness of AFHS designation, familiarity with the 4Ms, confidence in applying 4Ms principles, and educational priorities. A concurrent scoping review of

the literature identified evidence-based opportunities for integrating the 4Ms into stroke care and informed the survey questions.

Results: Of 1,055 clinicians invited to complete the survey, 130 responded (12.3%). Respondents included physicians (28, 21.5%), advanced practice providers (12, 9.2%), nurses (71, 54.6%), physical therapists (5, 3.8%), occupational therapists (1, 0.8%), speech-language pathologists (2, 1.5%), trainees (3, 2.3%), and other disciplines (9, 6.9%). Eighty respondents (61.5%) were from AFHS hospitals. Overall, 41.1% were aware that hospitals within the system held IHI AFHS recognition, increasing to 48.8% among respondents from AFHS hospitals. Most clinicians (70.8%) were either not at all familiar or slightly familiar with the 4Ms Framework; this was similar among respondents from AFHS sites (70%). Top educational priorities included: (1) stroke-specific shared decision-making, (2) strategies to reduce high-risk medication use, and (3) application of time-limited trials for complex decision-making.

Conclusion: Findings reveal limited awareness of the AFHS 4Ms Framework among stroke care clinicians, even within AFHS-recognized hospitals. These results highlight the need for targeted education and implementation of age-friendly principles to promote consistent, evidence-based, age-friendly care for older adults with stroke across a health system.

A83

A novel technique for eye drops administration; can this reduce the risk of ectropion?

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Currently, it is the usual practice to administer eye drops by pulling down the lower eyelid, and instilling the eye drops into the lower conjunctival sac.

Older people are the major users of eye drops. Ectropion prevalence, in the Blue Mountains Eye Study, was 6.7% of ages 70-79 years and 16.7% of those 80 years or older. Age related collagen loss, weakness of the orbicularis oculi muscle and the canthal tendons are some of the aetiological factors of ectropion.

When older people regularly and repeatedly pull the lower eyelid downward to instill eye drops, this may potentially affect the lower eyelid muscles, increase skin laxity, and increase the risk of secondary ectropion or worsen it.

Ectropion can lead to conjunctivitis, keratitis and even more serious complications, and may result in requiring surgical intervention.

We suggest a new technique, and that is to instill eye drops into the upper conjunctival sac (not the lower), to reduce the risk of contribution to ectropion. This can be achieved by administering the eye drops as follows: With the patient sitting down, they can carefully extend (tilt) the head backwards, hold the eye drops bottle between the index or middle finger and thumb, just above the eye, lift the upper eyelid gently with the index finger of the other hand, and instill the required eye drops dose as prescribed.

This technique should not affect the ocular absorption of medication, which is primarily through the capillary bed within the upper and lower conjunctival routes, or through the corneal route. Additionally, instillation into the upper conjunctival sac may benefit optimal absorption, as there is a deeper recess in the upper eyelid.

Older people should be sitting, rather than standing, while administering the eye drops, to reduce the risk of falling or experiencing dizziness. Many older people have cervical spondylosis and/or vestibular insufficiency; both can be symptomatic when the older person extends their neck to administer the eye drops. Patients who cannot sit down and extend their head can lie flat on their back.

The new technique needs to be clinically trialed to have the evidence to ensure safety and effectiveness.

A84

AI-native Digital Care Pathway for Frailty: Development and Simulation of a Predictive Line-of-Care Model to Prevent Acute Decompensations in Older Adults

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Background: Frailty is a major determinant of morbidity, disability, and healthcare expenditure among older adults. Evidence shows that 92% of severe decompensations are preceded by detectable clinical or behavioral signals 7–15 days before acute events, yet care delivery remains predominantly reactive. Predictive and AI-assisted care pathways may enable earlier intervention and continuity of care for vulnerable elders.

Methods: We developed a digital, AI-native line-of-care model for older adults with frailty, integrating: (i) risk stratification; (ii) continuous monitoring of clinical, functional, and behavioral signals; (iii) automated risk alerts; and (iv) multidisciplinary telehealth follow-up. The model was simulated using epidemiologic prevalence and utilization benchmarks for the U.S. older-adult population. Expected outcomes were estimated based on meta-analyses and large cohort studies evaluating remote monitoring, chronic care management, multidisciplinary telehealth, and adherence interventions.

Results: Simulation of a 1,000-patient frailty cohort projected a 24–38% reduction in unplanned hospitalizations, 18–32% reduction in emergency department visits, and 31–55% improvement in adherence to guideline-based therapy. The greatest modeled impact was observed in older adults with multimorbidity and ≥ 2 frailty criteria. Anticipated benefits were driven by early detection of destabilization alerts, intensified multidisciplinary management, and increased continuity of care.

Conclusions: An AI-native digital care pathway for frailty demonstrates strong potential to shift geriatric care from reactive to predictive management, improving clinical stability and reducing avoidable high-cost utilization. Real-world clinical validation is warranted to confirm long-term impact on outcomes, cost, and experience of care.

Keywords: frailty; chronic disease; artificial intelligence; digital health; telemonitoring; older adults; care coordination.

A85

To share or not to share: A systematic review of facility designs

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Background:

Delirium is highly prevalent among older adults residing in nursing homes and long-term care (LTC) facilities, where chronic illness, cognitive impairment, and functional decline heighten vulnerability to acute changes in mental status. Environmental factors including sensory stimulation, sleep quality, and opportunities for social engagement can play a significant role in the onset and course of delirium. However, the relationship between room occupancy type and delirium outcomes in geriatric populations remains unclear. This literature review aims to explore how facility designs can impact delirium in older adults living in LTC facilities.

Methods:

A systematic literature review was conducted to identify existing studies discussing delirium with regards to facility design. Keywords such as ‘single vs double occupancy’ ‘delirium’ ‘long term care’ ‘nursing home’ ‘residential care’ were used to find relevant articles. Most studies were conducted with US and Canadian residents.

Results:

During our research we found that single occupancy residents had a lower rate of delirium, infection and morbidity compared to double occupancy residents. Some of the factors this was attributed to were sleep disturbances, infection control (particularly during the COVID-19 pandemic) and use of psychoactive medication. We also noticed that the majority of the studies done in facility designs were in hospitals, indicating the need for more ongoing research.

Conclusion:

It is evident that room occupancy and design affects nursing homes and LTC residents. More research needs to be done in delirium rates as well as the risk of social isolation with single occupancy rooms. In doing so, nursing homes and LTC residents can have improved quality of life while minimizing complications.

A86

Implementing Narrative Medicine as a Matters Most tool in long-term care

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Background: The recently approved CMS 2025 Age-Friendly measures reinforce the need for discussions on Matters Most and goal-concordant care. Narrative Medicine programs, such as VA’s My Life, My Story, are valuable tools to facilitate these conversations. We describe a QI project that develops a sustainable workflow to explore “Matters Most” by integrating biographic narrative interviews into the long-term care setting, as part of the institution’s adoption of the Age-Friendly Framework.

Methods: Following the framework by Pronovost et al. (2008), we engaged nursing, social work, and physician leadership, volunteer services, clinician educators, and quality improvement teams to define roles, streamline workflow, and build a sustainable process for collecting patients’ stories. Volunteers and learners were trained to use an interview guide. A standardized workflow was developed to connect newly admitted residents to the Life Story team, including approaching patients and proxies, matching them with trained team members, collecting and reviewing their stories, and integrating the final document into the electronic health record. Evaluation will track workflow adherence and the number of completed Life Stories.

Results: A structured process map and workflow were developed and tested, demonstrating feasibility and guiding refinements. Staff feedback led to iterative revisions. Adaptive work included collaborating with IT to create a dedicated EHR location for Life Stories and moving its access icon to the summary page. To support sustainability, we plan to embed asynchronous virtual training modules on the institutional platform to orient incoming volunteers and learners, leveraging existing resources.

Conclusion: This project strengthens “Matters Most” work within our Age-Friendly implementation by using narrative medicine as a practical tool in long-term care. The implementation approach supports interprofessional collaboration and promotes sustainability. Next steps will be to study how the team incorporates information into Age-Friendly Care Plan meetings to develop person-centered goals and plans.

A87

Enhancing Long-COVID Education for Older Adult Survivors of COVID-19

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Background

The COVID-19 pandemic affected more than 776 million people worldwide, with an estimated 4–7% developing Long COVID, highlighting the need for patient education to support recovery and self-management. Older adults, who often experience multimorbidity, polypharmacy, and high healthcare utilization, may particularly benefit from tailored materials. The National Academies of Sciences, Engineering, and Medicine (NASEM) issued a consensus definition of Long COVID, prompting updates to existing resources. This project compared two COVID-19 Recovery booklets for Long COVID survivors.

Methods

A clinical innovation project was conducted within a longitudinal, multidisciplinary Long COVID program at the South Texas Veterans Health Care System in San Antonio, TX. Older adult survivors completed surveys between July-August 2025. Participants reviewed two brochures (Pre-NASEM and Post-NASEM). Likert items assessed five domains: visual appeal, clarity of the Long COVID definition, readability, informative graphics, and knowing how to get help. Open-ended responses to “How else can we improve the brochure?” underwent rapid content analysis to identify themes and improvement targets.

Results

Twelve paired respondents were analyzed. Both brochures were well received with direction of effect favoring the Post-NASEM booklet across all domains (Δ mean range +0.08 to +0.50). The largest gain was clarity of the Long COVID definition (Δ mean +0.50; Cliff’s delta +0.60), with agreement increasing from 66.7% (Pre) to 83.3% (Post). Other domains showed consistently high agreement (three domains at 100% agree at both timepoints) or small, non-significant increases; no domain remained statistically significant. Qualitative analysis of 14 comments highlighted themes of clarity and plain language, navigation and links, readability and formatting, and contact information and access. Additional signals included preferences for concise content, confirmation that graphics aided symptom understanding, and overall positive feedback.

Conclusions

Long COVID survivors viewed the Post-NASEM brochure favorably, with improved clarity, but no statistically significant differences compared with the Pre-NASEM brochure.

A88

Patient-Reported Sleep Quality After Implementation of a Multi-Modal Sleep Hygiene Bundle in Acute Care

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Background:

Hospitalized patients frequently experience poor-quality sleep. A Multi-Modal Sleep Hygiene (MMSH) bundle was implemented to improve sleep on acute care units. Patient feedback was collected to capture timely sleep quality reports.

Methods:

An electronic engagement platform sends patients text message surveys every other day after first 48 hours of admission, asking

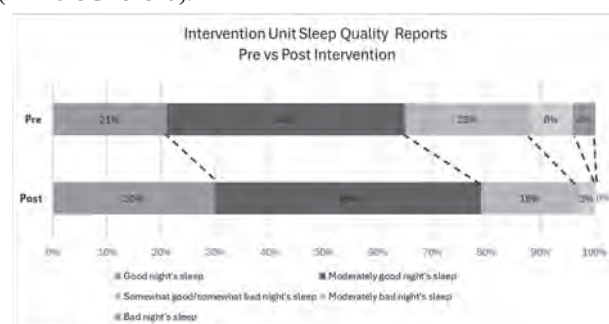
them to rate the preceding night’s sleep quality (5-point Likert scale). Response rates by age (above and below 70) and proportion of patient vs care-partner responses are collected. Demographics of older patients reported as proportions. Patient-reported sleep quality compared pre vs. post intervention in one unit. Data extracted between January to July 2025 (pre) and August to October 2025 (post).

Results:

Response rate for all ages was 23% of 9,879 surveys with 26% in older vs 20% in younger patients. In older, 59% of surveys were answered by patients and 41% by care partners (vs 87%, and 13% respectively in younger). Of older patients, 58% were female, 76% White, 15% Black, 3% Asian, 7% Hispanic. Among all patients contacted (8,800), 17% responded at least once (19% ≥ 70 ; 16% < 70). In intervention unit, sleep quality improved meaningfully post-intervention; Good or moderately good night’s sleep increased from 65% (51/78) to 78% (29/37). See Fig 1.

Conclusions:

Text message survey is effective in older and younger hospitalized adults in demographic distribution similar to hospital population. Implementation of MMSH bundle was associated with improvement in patient-reported sleep quality. Supported by PCORI (DE-2023C1-31325).



A89

Behavioral Intervention for People Living with Dementia: A Preliminary Pilot Study Using Eye-Tracking

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Background: The lifetime dementia risk is higher than estimated (Fang, 2025), emphasizing the need for rigorous evidence-based behavioral interventions for caregivers. This pilot study tested the fidelity of the first four steps of Positive Physical Approach (PPA), a widely used 12-step caregiver behavioral intervention that has not been experimentally tested. Developed by dementia educator Teepa Snow, PPA is a 20-second protocol using visual cueing and minimal verbal direction to foster meaningful person-centered interactions as a caregiver approaches a person living with dementia (PLWD). We propose testing PPA fidelity using the NIH Stage Model for Behavioral Intervention Development (Onken et al., 2014).

Methods: This experimental observations pilot study preliminarily tested visual attention of participants engaging with a caregiving in the first four steps of PPA and represents Stage I work within the NIH Stage Model. Using a novel approach, researchers employed eye-tracking technology to measure fixation and dwell time, on areas of interest related to the first four PPA steps. Twenty-seven undergraduate students viewed a 10-second video showing a simulated caregiver performing: Step 1: smiling at six feet; Step 2: raising hand near face (“hi” gesture); Step 3: verbal self-introduction; and Step 4: extending hand to shake.

Results: Paired-samples t-tests revealed significant changes in fixation dwell time across steps. From Step 1 to Step 2, dwell time on the face decreased, $t(4.10)$, $p < .001$ as focus shifted to the hand. Additional significant differences were observed from Step 2 to Step 3, $t(-3.46)$, $p < .01$, as focus shifted back to face, and Step 3 to Step 4, $t(2.90)$, $p < .01$, as focus shifted to extended hand.

Conclusion: These results suggest visual attention aligns with PPA's design in the first four steps, supporting its fidelity through cueing and limited verbal interaction while supporting the feasibility of eye-tracking as a method for evaluating behavioral interventions. Future studies should systematically examine the 12 steps of PPA with PLWD using the NIH Stage Model to establish fidelity, validate the intervention, and support the development of implementable behavioral interventions improving the well-being of PLWD.

A90

Application of Artificial Intelligence in a Narrative Medicine Program for Veterans

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Background: Patients' storytelling can build trust and support humanistic care. MyLife MyStory is a narrative medicine program in the Veterans' Affairs Healthcare System with observed benefits. A limitation of the program is the amount of time required for the collection and writing of each story - often about 4 hours. We evaluated the feasibility, acceptability and time saving of the use of artificial intelligence (AI) to capture, transcribe and summarize patients' stories.

Methods: We applied natural language processing features of the NVivo qualitative research software in a narrative medicine program based on MyLife MyStory. NVivo offered transcriptions and summaries of interviews with Veterans at the Miami VA. Veterans chose whether to include the narratives and/or AI summaries in their electronic medical records and/or to receive paper copies. Participants were asked to provide feedback and evaluate the feasibility and acceptability of the intervention using a survey and semi-structured interview.

Results: 40 Veterans participated. Mean age was 78 years, range 60 to 97 years. 20 participants (50%) were white, 17 (42.5%) were black/African American, and 3 (7.5%) were Native Hawaiian/Pacific Islander. Five (12.5%) were Hispanic. Settings of participation included outpatient clinics, inpatient hospital wards, a hospice/palliative unit and a nursing home. Time required for program processes tended to be 1 to 2 hours per patient. 38 Veterans responded with "completely agree" or "agree" to each item in the evaluation survey, and expressed support for the feasibility, acceptability and utility of the project in semi-structured interviews. Two Veterans endorsed neutral views of the program and not being comfortable with life review processes in general. Full agreement was expressed by the Veterans with the accuracy of their interview transcripts and AI summaries, and no concerns were raised regarding the use of AI.

Conclusions: Natural language processing features in NVivo software may enhance the feasibility and utility of VA narrative medicine programs, with considerable time savings and maintenance of acceptability.

A91

The Senior Medication Care Program: Impact of Continued Medication Access Services for Older Adults

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Background: High Point, NC hosts a large population of older adults with multiple barriers to medication access and has overlapping pharmacy and food deserts. Older adults in this city have significantly higher poverty rates than the rest of the population. To help overcome barriers to medication access and management in this community, the Senior Medication Care (SMC) program was created. Adapted from Durham, NC's Senior PharmAssist model, SMC is a free service where clinical pharmacists address the medication needs of older adults. The objective of this study is to describe the current impact of access services for older adults in High Point in year two of the SMC program.

Methods: Eligible participants are at least 60 years old, Medicare eligible, and are recruited by referral and at community outreach events. SMC pharmacists have mobile offices that meet participants at multiple locations in High Point. Access services include Medication Therapy Management (MTM), Medicare counseling, community referral, and copay assistance. Copay assistance includes providing eligible patients a secondary copay card for use at retail pharmacies, assisting with applications for Extra Help, and/or Patient Assistance Programs. Community referrals are made when participant needs are outside of SMC's medication access services (e.g., access to dental, vision, and nutrition support services).

Results: From January 1 to September 30, 2025, the SMC program assisted 24 older adults through 56 total unique encounters, a substantial increase from the program's 2024 pilot year which served 8 individuals. Participant ages ranged from 64-81 (average=72) and they took an average of 8 medications. Of the services offered, copay assistance was the most frequent (n=18) and included 12 assistance applications, 6 discussions about the SMC copay card, and 5 Extra Help application submissions. Medicare counseling constituted 9 appointments, and there were 3 MTM visits. Additionally, 9 community referrals were made to address broader needs.

Conclusion: The continuation of the SMC program has increased access to medication services for older adults in High Point. Since its launch, it has grown to expand access through strengthening community engagement and encouraging ongoing participation in the program.

A92

Dementia and Hearing Aid Use: A Brief Review of Adherence Barriers and Clinical Solutions in Geriatric Care

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Background

Hearing loss (HL), affecting up to 79.4% of persons living with dementia (PLWD), exacerbates communication deficits and caregiver strain, yet the real-world trajectory of hearing aid (HA) adherence among this population remains poorly characterized.

Methods

This targeted review synthesized empirical investigations from 2022–2025, identified through PubMed, Scopus, and Web of Science using pre-specified keywords ("dementia," "hearing aid," "adherence," "barrier", etc.). Studies were included if they enrolled adults ≥ 60 years with a dementia diagnosis and reported quantitative/qualitative HA adherence outcomes. Four studies, comprising three large observational cohorts (total $n > 380,000$) and one qualitative dyadic analysis, met inclusion criteria. Determinants of HA use and persistence were mapped to the Theoretical Domains Framework (TDF), elucidating cognitive, behavioral, and environmental factors.

Results

In Nieman et al. and Powell et al., women comprised 52.9% and 51% of participants respectively. Powell et al. also reported ~26% of participants as non-White. Dementia emerged as an independent determinant of HA discontinuation across all population-based studies. In the 2024 NHATS cohort (N=2,613), although 79.4% of PLWD presented with HL, only 21.7% utilized HAs. VA data (N=380,794) showed a 54% reduction in the odds of sustained HA use among those with dementia. Furthermore, a U.S. registry (N=1,310) revealed dementia more than doubled the odds of HA cessation within 12 months. Qualitative dyad analysis exposed barriers stemming from impaired memory, manual dexterity, limited caregiver support, and delayed troubleshooting; TDF-aligned facilitators included caregiver embedded routines, the adoption of rechargeable auto-on devices, and proactive follow up, 2–4 weeks post-fitting.

Conclusions

The intersection of dementia and HL undermines HA adherence through cognitive, behavioral, and environmental mechanisms that transcend device availability. Clinical geriatric paradigms must advance toward dementia-competent auditory care models, embedding HAs into daily routines, easing device handling, and empowering caregivers through structured education and timely follow-up.

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A93

Growing Wellness: Gardening Pilot Program for Homebound Older Adults and Caregivers

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Background

Social isolation and limited meaningful activities affect homebound adults and their caregivers, who often experience high stress due to limited support and few opportunities for shared positive engagement. We piloted a home-based gardening program to assess feasibility and impact on caregivers, home-bound veterans, and home-based primary care (HBPC) team.

Methods

HBPC team members identified caregivers interested in a Spring 2025 gardening pilot. Nine caregivers participated. Each received an outdoor gardening box with materials (soil, seeds, plants) and a 1-hour HBPC-led instruction. Volunteer funds paid for supplies. In Fall 2025, de-identified caregiver experience/well-being and HBPC team surveys were completed.

Results

A 3-point Likert Scale (not at all, somewhat, very much) was used. All participants were highly satisfied (very much) with the program and reported mood improvement (9/9). Caregivers reported eating more fruits and vegetables (6/9 very much, 3/9 somewhat), feeling healthier (8/9 very much, 1/9 somewhat), and a greater sense of purpose (6/9 very much, 3/9 somewhat). Zarit 4-item burden scores were very low at baseline and slightly decreased post-program. Comments highlighted the joys of watching things grow, rekindling old interests in gardening, a sense of accomplishment, and wanting a second garden.

4 HBPC RNs and 1 Psychologist who led the program were surveyed. All (5/5) reported a very positive impact on patients and caregivers and most felt the program very much enhanced their sense of purpose at work (4/5). Workload was considered very manageable (3/5) and somewhat (2/5). They most enjoyed: caregiver and veteran engagement and pride in garden growth. Suggested improvements included more check-ins, recipe sharing, and adding fall plants.

Discussion

The home garden pilot demonstrated a significant caregiver impact in improved health, mental well-being, and social connection. Staff reported positive impact and feasibility in workload. Limitations included, small number, so unable to show significance in Zarit caregiver survey. This data focused on caregiver experience, we plan to further study impact on the veteran and add instructions and indoor plantings to involve the veteran in the gardening process. Staff also plan to further integrate into the interdisciplinary workflow.

A94

Development and testing of myHealthLLM Chatbot for older adults with multiple chronic conditions

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Background: Over 80% of older adults in the U.S. have multiple chronic conditions (MCC) and many struggle with ‘making sense’ of their own health conditions and treatment protocol. According to cognitive load theory, when there is an information overload or if the information complexity is high, people give-up trying to understand. Large Language Models (LLMs) can be used for analyzing, interpreting and communicating complex and difficult to understand personal health data to older adults with MCC.

Objectives: The objective is to develop and test an LLM Chatbot that could conduct comprehensive analysis of self-reported data to discover trends and patterns in symptoms, enable users to query in natural language, and offer personalized and actionable health insights.

Methods: We developed myHealthLLM using Ollama, an open-source LLM runtime, to run the Mistral-7b model directly on our rented GPU server. The front-end portal was added to a pilot tested Web-based Comprehensive Digital Self-care Support System (CDSSS) that collects customized data on over 55 symptoms or health conditions, including physical, mental and social health of older adults with MCC. The LLM is fine-tuned and trained to parse through a MySQL database with the user’s userID, find correlations and patterns, and use that data to answer user queries in simple language. We tested it with the data of 5 past users of the CDSSS for accuracy and appropriateness. This data includes all health conditions, medication data and daily tracking data of symptoms for 4 weeks for each user. Our questions included simple questions e.g. “What are my medications” to slightly complex questions e.g. “Why do I have leg pain?”.

Results: The myHealthLLM was able to access the MySQL database and provide accurate answers for simple questions, though additional training would be needed for more complex questions. The answers also need to be evaluated for appropriateness.

Conclusion: The results indicate the potential of using myHealthLLM to improve older adults’ sense-making of health concerns and thereby hold implications for behavior change and patient engagement, as it could provide actionable insights to older adults regarding their health.

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Breathing in Harmony: An Innovative Harmonica Program to Improve COPD Care in Veterans

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Chronic obstructive pulmonary disease (COPD) is a leading cause of morbidity among Veterans, contributing to dyspnea, decreased functional capacity, and impaired quality of life. While pharmacologic and rehabilitative interventions remain the cornerstone of management, innovative, low-cost strategies to improve symptoms and engagement are needed.

At our VA Medical Center, we piloted a harmonica-based program as an adjunctive intervention for Veterans with COPD. Playing the harmonica requires coordinated inhalation and exhalation against resistance, which may strengthen respiratory muscles, promote diaphragmatic breathing, and improve breath control. In addition to its physiologic benefits, group harmonica sessions foster social connection, reduce isolation, and promote joy in self-expression.

Veterans participating in the program reported subjective improvements in breathing, increased awareness of breath control, and enhanced confidence in managing symptoms. Several participants described reduced anxiety associated with dyspnea and greater adherence to home practice. Importantly, the program created a supportive community that facilitated shared learning and peer encouragement.

This pilot suggests that harmonica playing may represent a scalable, enjoyable, and cost-effective intervention for Veterans with COPD. Beyond its potential clinical benefits, the program highlights the value of creative approaches that integrate physical, emotional, and social dimensions of care. Future directions include formal evaluation of respiratory outcomes, impact on quality of life, and potential expansion to additional patient populations.

This innovative program reflects the VA's commitment to whole-person care, aligning clinical goals with meaningful activities that resonate with Veterans. By harnessing music as therapy, we can help Veterans breathe more easily—while also inspiring resilience, connection, and joy.

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Inpatient Virtual Geriatric Consult Service in a Rural Critical Access Hospital: Feasibility, Implementation, and Early Outcomes

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Background:

Rural US communities have a high proportion of older adults (19.2% aged >65 vs 15.7% in non-rural areas); yet access to geriatric medicine is limited. A National analysis shows that 63.9% of U.S. counties—primarily small and non-metropolitan—lack geriatricians. To address this gap, a rural critical access hospital in Illinois partnered with geriatrics team at a large academic medical center in Chicago to develop a structured inpatient virtual geriatric consult service (VGCS).

Methods:

Program development began in Dec 2024 with meeting key stakeholders (hospitalist, nursing staff and leadership) to define referral criteria and workflows. Goals included reducing readmissions and length of stay, minimizing polypharmacy and improving discharge planning. Patients aged 65+ with recurrent falls, delirium, agitation, or medication concerns were eligible.

The VGCS used two structured tools: a pre-consult packet (Confusion Assessment Method, Mini-Cog, and Geriatric Depression Scale) and a caregiver intake form covering mobility (ADLs/IADLs, gait, walking tolerance), medication review, and nutrition screening. Consults were placed through the EMR, and the charge nurse coordinated completion of intake forms, scheduling consults and arranged visits with an iPad. Recommendations were documented in structured EMR templates and reviewed in interdisciplinary huddles. Key implementation steps included: Dec 2024 planning meetings; Jan 2, 2025 program launch; Jan 9, 2025 shift to automatic consults for patients aged 65+; Feb 12, 2025 revision and shortening of forms based on nursing feedback; and Aug 22, 2025 addition of recommendations into the After-Visit Summary.

Results:

Over the first eight months, 48 inpatients were evaluated. Early implementation challenges included troubleshooting virtual visits,

clarifying referral criteria, and training staff to use the assessment packet. The hospital's limited 21-bed capacity also affected census and consult volumes.

Conclusion:

A structured virtual inpatient geriatric consultation service can be successfully implemented in a small rural critical access hospital. With support from a remote geriatrics team and clear workflows, the program helped address a significant gap in geriatric assessment. This model may be useful for other rural hospitals that do not have on-site geriatric specialists.

A97

HOPE-TLC: An Innovative Model of Care Supporting People Living with Dementia Transitioning from Acute to Long-Term Care

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Background: People living with dementia (PLWD) sometimes are brought to the hospital when they or their caregivers are in crisis. In some situations, a transition to long-term care (LTC) is needed; PLWD may experience a long length of stay in the hospital, and are at risk for hazards including debility, polypharmacy, and delirium. We developed a care model to support PLWD as they transition from hospital to LTC, built upon the Health Optimization Program for Elders (HOPE) model previously created at this institution.

Methods: Our site is a 388-bed community hospital affiliated with a major academic health system, with a geriatric consult service. Geriatricians are consulted to see PLWD and give recommendations for behavioral care plans and medication management. We developed a program where a nurse practitioner (NP) follows PLWD in the hospital to provide recommendations and support nursing staff, and also provides follow-up upon discharge from hospital to LTC for a 4-week transitional period. We partnered with two local memory care facilities to pilot the program and perform in-person NP follow up visits. A Strengths, Opportunities, Aspirations, and Results (SOAR) analysis was performed to assess stakeholder experiences with the program.

Results: Six people participated in the SOAR: 3 providers, 2 case managers, and 1 administrator. SOAR results are captured in Table 1.

Conclusions: This innovative model of care supporting PLWD transitioning from hospital to LTC has been found to improve communication between team members and entities, and led to positive impacts on under-served PLWD. Development opportunities include formalizing program structure and improving secure communication methods. Future goals include program expansion. Next steps include measuring patient and system outcomes and expanding to include more LTC partners.

SOAR Results

Strengths	- Open communication (weekly room calls, in-person NP visits, as-needed phone calls) - Improved collaboration between entities to brainstorm and close care gaps - Positive impacts for under-resourced PLWD
Opportunities	- Targeting medication reconciliation accuracy - Consistently communicating non-pharmacological symptom management across care settings - Improving efficiency throughout the discharge planning and transition process - Increasing interprofessional collaboration and formalizing discussion structure for post-discharge follow-up visits
Aspirations	- Expanding to more facilities while maintaining close relationships - Having a 24/7 on-call geriatrics provider available when a PLWD is in crisis - Hospital system sponsorship of PLWD transitioning to LTC while awaiting guardianship and/or funding
Results	Developing a secure communication portal and HIPAA-compliant LTC access to patient hospital records

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Characterizing Medication Beliefs and Attitudes Toward Deprescribing in Aging World Trade Center Responders: Insights from a Pilot Sample

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Background: 9/11 World Trade Center (WTC) rescue and recovery workers, uniquely exposed to 9/11 environmental toxicants, are aging with high rates of multimorbidity and polypharmacy. This pilot study characterized medication profiles, beliefs about medicines, and attitudes toward deprescribing in a targeted sample of responders engaged in a deprescribing education initiative.

Methods: WTC responders ≥ 50 years from the Mount Sinai WTC Health Program participating in a deprescribing education initiative (4/8/2025–present) completed the Beliefs About Medicines Questionnaire (BMQ) and the Revised Patients' Attitudes Toward Deprescribing (rPATD). BMQ necessity and concern subscales were dichotomized to derive four attitudinal constructs: In-favor (low concern/high necessity), Distrustful (high concern/low necessity), Indifferent (low concern/low necessity), and Mixed-feelings (high concern/high necessity). rPATD factor scores assessed perceived burden, appropriateness, concerns about stopping, and involvement in decision-making. Descriptive statistics and bivariate correlations (Pearson's R) were performed.

Results: The sample included 15 participants (mean age 64.2 ± 5.1 years; range 52–76; 73% male), prescribed 13.3 ± 4.7 medications each. High-risk Beers Criteria medications were common: 93% used proton pump inhibitors and 7% benzodiazepines. Participants reported heterogeneous beliefs in medication necessity (mean 15.1 ± 4.0) and low concerns about long-term effects, dependence, and disruption (mean 11.2 ± 3.4). BMQ attitudinal distributions were: 40% In-favor, 47% Indifferent, 7% Mixed-feelings, and 7% Distrustful. BMQ necessity correlated with total medication count ($R=0.58$, $p=0.02$) and rPATD perceived burden ($R=0.56$, $p=0.03$).

Conclusions: Aging WTC responders exhibit complex, heterogeneous medication beliefs and attitudes toward deprescribing. These findings will enable us to create deprescribing tools that align with how WTC responders think and feel about their medications to enhance medication safety, reduce polypharmacy, and guide patient-provider conversations in this vulnerable aging population.

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Inpatient MOBility Safety Functional Evaluation (IMOBISAFE) Tool Development

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Background: Mobility is a key determinant of health outcomes in older adults, reflecting the integration of physical and cognitive functions, especially during acute hospitalization. Routine bedside assessments often focus on motor performance and functional capacity, and do not fully integrate elements critical for safe mobility, such as cognition. The goal of this project is to develop a bedside tool that could be used by multiple levels of care providers (not just nursing) to assess unsafe, at-fall-risk behaviors in hospitalized older adults.

Methods: A multidisciplinary team – including two therapists (occupational, OT and physical, PT), and two geriatricians (one a mobility and falls expert) – reviewed existing hospital mobility assessment tools as well as standard PT and OT mobility safety assessments. A short supine to standing and stepping protocol that mimics key standard bedside mobility includes subtasks of supine to sit, sit to stand, stance, stepping in place, and standing pivots, all with walker support.

A mobility-relevant dressing task (donning socks) was also added. Older adults (aged ≥ 60) hospitalized on acute medical-surgical units, deemed by the nurse manager to be at fall risk but able to safely cooperate, will be recruited. Initial piloting has just begun to determine feasibility.

Results: The one-page Inpatient MOBility Safety Functional Evaluation (IMOBISAFE) tool (to be presented), integrating a series of short (≤ 3 step) commands as well as a scoring sheet was developed. For safety, patients wear a gait belt and are within arm reach of the assessor. Within each subtask (e.g. supine to sit), the patient will be assessed for any requirement of assistance (either verbal cue or light physical support) and for behaviors indicating unsafe at-fall risk behaviors. Examples of at-fall risk behaviors during the various subtask performance include “overshooting” trunk sway, inability for the foot to clear the floor and tipping the walker.

Discussion: This novel IMOBISAFE tool broadens acute hospital mobility assessment beyond motor performance and functional capacity by capturing unsafe, at-fall-risk behaviors and mobility impairment. The eventual goal is to direct care plans to address these at-risk behaviors and measure the effect on increasing inpatient mobility and the reduction of acute hospital falls.

A100

Perceived Psychological Benefits Following a Cognitive Intervention: Experiences of Older Adults with Breast Cancer

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Background: Older adults with cancer (OAC) frequently experience cancer-related cognitive decline (CRCD), a multidimensional condition influenced by biological and psychological factors, including anxiety and depression. Given the association between CRCD and distress, interventions tailored to address cognitive functioning may offer secondary psychological benefits. We examined OAC's perceived benefits on psychological health after participating in an intervention designed to mitigate CRCD.

Methods: Secondary analysis of a study evaluating a cognitive behavioral therapy (CBT)-based intervention incorporating structured stress-management components (Memory and Attention Adaptation Training-Geriatrics; MAAT-G) versus supportive therapy (ST) among adults 65+ with breast cancer receiving systemic treatment. Both arms received ten weekly, individualized sessions via Zoom by a trained clinician. At study completion, subjects participated in semi-structured interviews exploring their intervention experience. Data was interpreted using thematic analysis. Two coders independently identified codes, categories, and themes per intervention arm before meeting to compare and synthesize findings until consensus was reached.

Results: Twenty MAAT-G participants described psychological benefits attributable to the intervention. In contrast, only 3 ST participants described similar effects. Table 1 shows the themes that emerged in each arm.

Conclusions: Participants in both MAAT-G and ST reported reduction in anxiety and stress; however, ST participants expressed interest in additional relaxation techniques. MAAT-G participants perceived benefits of the intervention, consistently describing muscle relaxation and meditative practices as providing both immediate and preventative distress relief. These findings suggest that incorporating structured stress-management training in CRCD interventions may improve psychological well-being among OACs.

Themes expressed among MAAT-G and ST participants

Intervention Arm	Qualitative Theme	Category
Memory and Attention Adaptation Training - Geriatrics (MAAT-G)	Neuropsychological benefits	1. Improvements in stress 2. Improvements in sleep 3. Improvements in cognition
	Additional tools/skills	1. New tools 2. Managing daily stressors
	Planning	
	Perception of relaxation techniques	1. Helpful perceptions 2. Critiques and suggestions
Supportive Therapy (ST)	Relaxation as a preventative measure	
	Reflective listening brings awareness	
	Desire for further support Talking as a relaxation technique	

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Pilot Study Assessing Oral versus Intravenous Benzodiazepine Sedation for Cataract Surgery

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Background: Cataract surgery is a common elective procedure for older adults. Intravenous (IV) sedation administered by anesthesia professionals is the standard of care in the United States. However, oral benzodiazepine sedation can be safely delivered by non-anesthesia clinicians, which reduces resource strain and limits systemic risks from IV sedatives. Few studies examine these approaches, and none evaluate postoperative functional or cognitive recovery by sedation route. This pilot study assesses the feasibility and acceptability of oral versus IV sedation for cataract surgery and collects early recovery data to guide a larger single-center trial at UCSF.

Methods: Feasibility was assessed by examining recruitment, retention, randomization, and completion of study activities. Acceptability was evaluated with the Iowa Satisfaction with Anesthesia Scale (ISAS). Functional and cognitive recovery at baseline, in the post-anesthesia care unit (PACU), and on postoperative day 1 (POD1) and postoperative day 7 (POD7) was measured with the Postoperative Quality of Recovery Scale (PQRS). Ambulatory patients aged ≥ 65 were recruited and randomized in a 1:1 ratio using randomly permuted blocks of 2, 4, and 6 on the day of surgery by the UCSF Investigational Drug Service (IDS) to receive oral sedation with alprazolam (0.5 mg) and IV placebo or IV sedation with midazolam (1 mg) and an oral placebo pill.

Results: 16 study patients have been enrolled (target $n=20$) with a mean age of 72.8 years (SD 4.8); 62.5% were female, and 68.8% were White. Baseline assessments were completed by 100% of patients, with 93.8% completing PACU and POD1 assessments and 87.5% completing POD7 assessments. Of 104 patients contacted, 41.3% were fully screened and 15.4% enrolled. ISAS satisfaction was 60%, 73%, and 73% at PACU, POD1, and POD7, respectively. PQRS cognitive recovery was 100%, 80%, and 86% at the same time points.

Conclusions: All study participants were successfully randomized by the IDS, and blinding was maintained. Protocol violations were minimal, and most participants completed all assessments. Participants reported satisfaction with their anesthesia experience, and most returned to baseline cognition by POD7. These preliminary findings support the feasibility of a larger trial evaluating sedation route and postoperative recovery.

A102

Integrating Robotic Pets in Acute Care: Implications for Dementia Care in Hospitalized Older Adults

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Background: People with dementia experience twice as many hospitalizations annually when compared to other older adults.¹ This study aimed to examine the clinical benefits of providing patients

with dementia with a robotic pet companion during their hospital stay. **Methods:** This randomized controlled trial enrolled older adults admitted to medical-surgical units at a community-based hospital. Patients were ≥ 65 years, had a history of dementia, and 0-4 NuDESC score. Patients randomized to the intervention group received a Joy for AllTM robotic pet ($n=52$) while those in the control group ($n=54$) received the SOC. Demographic and clinical data were collected from enrollment up until discharge. Analysis of covariance, Chi-square, and McNemar's tests were used to compare clinical outcomes within and between groups. **Results:** The average age for patients was 87 years. Patients were primarily White (99.1%) and female (72.6%) and admitted from an assisted living facility (ALF) (50%) or home (33%). Change in NuDESC score from baseline to discharge did not differ significantly between the two groups ($p=0.64$). Although not statistically different between the two groups, the intervention group had fewer restraints, less constant observation orders, and no falls or code greys. Comparison of vital measurements demonstrated fewer episodes of hypotension and bradycardia among those receiving a robotic pet compared to the control group ($p<0.001$). Patients in the intervention group were more likely to be discharged home when admitted from home (47%) or ALF to ALF (65%), compared with the SOC group. Individuals in the SOC group were also more likely to require a higher level of care upon discharge. **Conclusions:** The findings suggest that providing robotic pets to patients with dementia during hospitalization may improve clinical outcomes. This intervention was well-received by bedside nursing staff and caregivers, highlighting its practical benefits and acceptability in clinical settings. However, additional research is needed to understand the role of robotic pets beyond the acute care setting and across other nursing units.

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A103

Exercise Adherence And Executive Function – Chicken or Egg?

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Background: Despite the many proven benefits of exercise, the majority of older adults in the US remain sedentary. There are several barriers to physical activity such as poor access, lack of transportation, costs, and accepted stereotypes of elderly lifestyle. Impairment in executive functions is also linked with poor adherence to exercise programs. The goal of this study was to evaluate the connection between executive function and exercise adherence.

Methods: Participants aged 60 years and older with a sedentary lifestyle ($N=72$) were enrolled in a home-based exercise program. Two weeks of training was built in for safety assessment and learning the program. Subjects then performed the exercises at home for 12 weeks. Executive function (EF) was measured using the Connors performance test hit reaction time and hit reaction time standard error. EF was measured at baseline and at 3 months. Adherence to the home-based exercise program was assessed at 3 months. Participants with 80% or higher compliance were considered to have good adherence.

Results: Mean age of the participants was 68.4 (± 5.7) years, 67% were male, 61% were Caucasian, 33% were African American, and 96% were non-Hispanic. 51% were married, 76% were retired and the group had 14.7 (± 2.3) mean years of education. On average, participants had 8.5 (± 3.6) comorbidities and took 9.2 (± 4.5) medications. The mean MoCA score was 27.4 (± 1.2). At baseline, 64% of the participants had good executive function. At 3 months, 71%

of the participants had good executive function. At 3 months, only 29% of the participants had good adherence to the exercise program. Changes in executive function at 3-month visit was assessed according to the adherence. There was a statistically significant improvement in the executive function ($p=0.013$) in the participants who adhered to the program compared to those who did not adhere to the program.

Conclusion: While good executive function is important for exercise adherence, if someone adheres to an exercise program, their executive function improves.

A104

Improvement in Motivation and Anhedonia Across Age Groups in Major Depressive Disorder

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Background:

This study investigated changes in depressive symptoms among individuals with major depressive disorder (MDD) treated with standard antidepressants, focusing on early improvement in anhedonia (loss of interest, pleasure, and motivation), which often precedes overall mood recovery. Age-related differences in emotional and motivational responses to treatment were also examined.

Methods:

Adults diagnosed with MDD and receiving antidepressant therapy participated in online interviews using the Ad-Infer EVAL system, a tool designed for positive and differential AI diagnosis assessment and data collection. The first wave (W1) occurred from May to October 2024 and the second (W2) from September 2024 to March 2025, with a 56.4% follow-up rate. The final adjusted sample included 75 participants on fluoxetine or paroxetine (GR1), 44 on bupropion (GR2), and 40 on vortioxetine (GR3), stratified into 3 age groups: <35 ($n=30$), 35–54 ($n=81$), and ≥ 55 ($n=48$) years. McNemar tests were applied within groups; Bonferroni-corrected chi-square tests were applied between groups.

Results:

Most participants were female (GR1, 81.0%; GR2, 54.5%; GR3, 77.5%). By W2, MDD prevalence declined by 14.0% in GR1, 30.1% in GR2, and 20.0% in GR3 with no significant differences between age groups. Relapse was more frequent in GR1 (87.0%) than in GR2 (50.0%) and GR3 (51.5%; $P<0.001$). Younger adults in GR3 and middle-aged adults in GR2 showed significant motivational improvement (increases of 23.6% and 26.9% respectively, while older adults in GR3 demonstrated a marked reduction in anhedonia (42.9% to 15.4%; $P=0.0004$), contrasting with increases in GR1 (20.8% to 54.2%) and stability in GR2 (50%) ($P<0.005$ between GR1 and both groups).

Conclusions:

Vortioxetine demonstrated broad benefits on motivation and anhedonia, particularly among older adults, suggesting age-sensitive antidepressant responses. Bupropion produced sustained motivational gains in younger and middle-aged adults, consistent with its dopaminergic–noradrenergic action, although improvements in anhedonia were less evident across age groups.

A105

Management of Uncertainty in the Context of Cancer-Related Cognitive Dysfunction in Older Adults with Breast Cancer

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Background: Uncertainty is a universal part of life, and especially salient to those navigating cancer. Uncertainty within these diagnoses is a distressing state where people cannot conceptualize the illness, its meaning, or its prognosis. Prior studies in cancer patients associate greater intolerance of uncertainty (IU) with worse psychological distress and cognitive function. Thus, IU is important to explore when studying interventions that provide education and compensation strategies for cancer-related cognitive dysfunction (CRCDD). We evaluated the effect of two CRCDD interventions on reducing IU.

Methods: We conducted secondary analysis of a pilot study evaluating supportive therapy (ST; a reflective listening intervention) and Memory and Attention Adaptation Training–Geriatrics (MAAT-G; a cognitive-behavioral therapy-based intervention). Both conditions included 10 sessions delivered one-on-one by a health professional. Eligible patients were aged 65+ years with breast cancer receiving systemic therapy. Participants completed a self-report measure of IU before and after receiving ST or MAAT-G. Changes over time and group-by-time interactions were analyzed using linear mixed-effects models with random intercepts.

Results: Sixty-nine female participants were enrolled (MAAT-G $n=34$, ST $n=35$; mean age 70.4 ± 5.4). Over half (55.1%) were receiving treatment for localized cancer. The sample was well educated (58.0% held at least a college degree) and most were partnered (59.4%). Clinical, demographic, and IU baseline scores were comparable between arms.

Both MAAT-G and ST produced significant reductions in IU over time ($F=5.27$, $p=0.025$). The magnitude of change was comparable between the two interventions ($F=0.649$, $p=0.423$).

Conclusion: This is the first analysis to evaluate the effect of CRCDD interventions on IU. Both ST and MAAT-G produced significant and comparable reductions in IU. Longer-term studies are needed to assess durability and sustained benefits.

A106

Strategies to Recruit Older Women with Urinary Incontinence: Lessons from the MoVEonUP Trial

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Background:

Mobility and Voiding Exercises in Older Women with Urinary Incontinence (MoVEonUP) trial is a single-site, randomized controlled study evaluating a home-based multicomponent intervention to reduce urinary incontinence (UI) and falls in community-dwelling women aged ≥ 70 years. Participants were recruited using a multipronged strategy that integrated health system-based methods with community engaged strategies. This report describes recruitment strategies, outcomes, and challenges.

Methods:

Health system recruitment involved identifying eligible women through electronic health records (EHR), clinician referrals, and flyers in affiliated clinics. Community engagement involved partnerships with local organizations to deliver 30-minute bladder health education sessions and conduct outreach at senior centers, residential

complexes, and faith-based organizations. Recruitment metrics, including referral source, screening eligibility, and enrollment outcomes, were tracked throughout the study.

Results:

Recruitment occurred from June 2022 to August 2025. EHR screening identified 12,832 women aged ≥ 70 with a documented UI diagnosis. Each eligible contact received three recruitment emails, and 10,000 received two additional messages. Presentations were delivered to geriatrics, primary care, urology, and urogynecology faculty, and flyers were distributed throughout affiliated clinical practices. Community engagement activities included 51 educational sessions and 23 health fairs, collectively reaching 1,818 adults. Overall, 932 women completed prescreening and 375 ultimately consented to participate.

Conclusions

A multifaceted recruitment strategy, integrating large-scale EHR-based identification with sustained community engagement, was essential for reaching older women with UI. Health system-based outreach allowed broad reach but low response rate. Community engagement increased study visibility and helped build trust but required substantial time and personnel resources to plan and implement. Future trials targeting older populations may benefit from hybrid approaches that combine electronic communication tools with trusted, in-person community partnerships to enhance reach, improve engagement, and support diverse and representative enrollment.

A107

Do males compensate for age-related neural decline more than females? Findings from a psychometric network analysis

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Background:

Sex differences in late-life cognition are well documented, but most studies focus on mean performance rather than the structural organization of cognitive processes. Psychometric network analysis offers a novel approach to uncovering how cognitive components interact and whether these patterns differ by sex and age.

Methods:

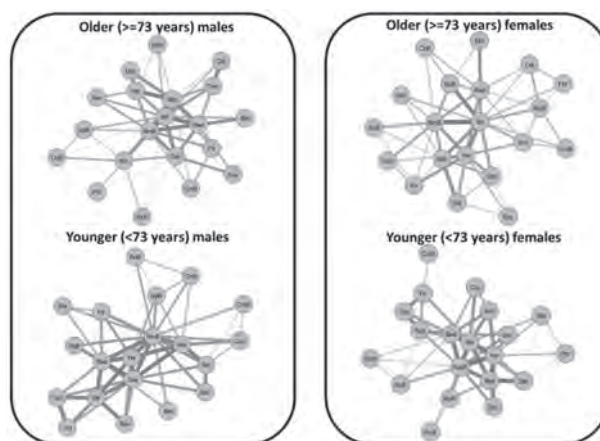
This study analyzed baseline Mini-Mental State Examination (MMSE) data from 2,802 well-functioning older adults (aged 65 years or older) enrolled in the ACTIVE study. Networks were estimated separately for males ($n = 676$) and females ($n = 2,125$) using the Triangulated Maximally Filtered Graph method for dichotomous data. Complementary analyses stratified participants by age (<73 vs. ≥ 73 years). Network properties included overall structure, positive and negative connections, and strength centrality.

Results:

Both sexes exhibited a single general cognitive network with language naming as the most central process. However, males showed more negative connections between cognitive components ($N = 9$) than females ($N = 1$), suggesting greater reliance on compensatory mechanisms. Age-stratified analyses revealed that younger females (<73 years) displayed early compensation ($N = 4$ negative connections), whereas younger males had none. Older males (≥ 73 years) retained more negative connections than older females, indicating sex-specific trends in neurocognitive adaptation.

Conclusions:

Negative associations between cognitive processes may reflect compensatory reorganization in response to neural decline. The findings suggest that males compensate more extensively in later life, while females may initiate compensation earlier. These patterns underscore the importance of examining cognitive networks—not just mean scores—when addressing sex differences in aging and designing interventions to enhance cognitive resilience.



A108

Cannabis Use Disorder among Older Adults Who Use Cannabis in the United States

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Background: Cannabis use is increasing among older adults in the United States (U.S.). However, little is known regarding cannabis use disorder (CUD) in this population. We aimed to estimate the prevalence of CUD among older adults who use cannabis and delineated correlates associated with meeting clinical thresholds.

Methods: This study used the 2022-2023 National Survey on Drug Use and Health, an annual cross-sectional nationally representative survey of noninstitutionalized individuals in the U.S. Focusing on the subsample of 10,250 adults aged ≥ 65 , we estimated the prevalence of proxy diagnosis of DSM-5 CUD (≥ 2 criteria) among adults aged ≥ 65 who used cannabis in the past 12 months. We compared the prevalence of CUD across sociodemographic and health characteristics, modality of cannabis use, and individual CUD criteria. Unadjusted generalized linear regression models estimated the relative risk (RR) of CUD by each characteristic and modality of use.

Results: Among the 8.8% of all older adults who used cannabis in the past year, 10.9% met criteria for CUD. The majority of older adults with CUD (67.1%) met 2 or 3 criteria (mild CUD). The most common CUD criteria met were “a great deal of time is spent in activities necessary to obtain, use, or recover from its effects” (84.9%), “craving or a strong desire or urge to use” (72.7%), and “tolerance” (57.8%). Older adults with CUD were more likely to be men (vs. women; RR=2.11, 95% CI: 1.09–4.10) have any past-year mental illness (vs. none, RR=3.83, 95% CI: 2.09–7.03), use tobacco (RR=1.77, 95% CI: 1.09–2.88), use drugs other than cannabis (RR=3.92, 95% CI: 2.35–6.54), report smoking as mode of cannabis use (vs other routes of use; RR=3.22, 95% CI: 1.35–7.67), and report frequent cannabis use (e.g., ≥ 260 days vs. <260 days, RR=4.84, 95% CI: 2.68–8.71).

Conclusions: Over a tenth of older adults who have used cannabis in the past 12 months met criteria for CUD. Among older adults who use cannabis, those with mental health comorbidities and reporting other substance use may be at particular risk for CUD. Results reaffirm the importance of discussions regarding cannabis use among older adults and screening for CUD among those who use cannabis to minimize potential harms and refer for treatment.

A109

Incident dementia and RSV vaccination: VA nursing homes study

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Background: Infections such as COVID-19, influenza, respiratory syncytial virus (RSV), and shingles have been linked to higher dementia risk, and vaccines against these pathogens may offer neuroprotection. The RSV vaccine received FDA approval on May 3, 2023, and its potential effect on incident dementia remains unclear. This study evaluated associations between RSV vaccination and dementia among Veterans Affairs (VA) Community Living Center (CLC) residents.

Methods: We conducted a retrospective case-control study of VA CLC residents aged ≥ 65 years ($N=73,391$). Electronic medical records were used to identify RSV, influenza, and COVID-19 vaccination status. Dementia diagnoses were determined using ICD-10 codes. Cases were residents newly diagnosed with dementia between May 3, 2023, and Nov 5, 2025; controls had no dementia during follow-up. Vaccinations administered before each participant's index date were included in multivariable logistic regression models.

Results: In 2024, dementia occurred in 3,609/14,691 (24.6%) unvaccinated vs 301/2,150 (14.0%) vaccinated residents ($RR=0.62$; 95% CI 0.56–0.69). In 2025, dementia occurred in 3,739/6,707 (55.8%) unvaccinated vs 233/711 (32.8%) vaccinated residents ($RR=0.67$; 95% CI 0.59–0.75). However, when adjusting for age, COVID-19 and influenza vaccination status there was no statistically significant association with dementia ($OR = 0.97$).

Conclusions: Among VA nursing home residents, RSV vaccination was not associated with incident dementia in preliminary work possibly reflecting differences in the population due to healthcare utilization. Further investigation is required to better understand this association and determine potential confounding.

A111

Age-Dependent Association Between Hearing Loss and Stroke Risk in Patients With Atrial Fibrillation: Insights From a Longitudinal Taiwanese Cohort

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Background

Hearing loss is common in older adults and increasingly viewed as an indicator of multisystem aging. Its relationship with atrial fibrillation (AF)-related stroke risk is unclear. Prior work suggests possible shared mechanisms—such as ion channel dysfunction—linking AF and some forms of sensorineural hearing loss. Whether hearing impairment alters stroke risk differently across age groups remains unknown.

Methods

We examined the association between hearing loss and the risk of stroke in a hospital-based, longitudinal cohort of 24960 patients with AF who had no prior history of stroke. The cohort was enrolled from Jan. 2010 to Dec. 2021. The primary outcome was ischemic stroke. Participants were stratified by age <60 , 60–74, and ≥ 75 years. Cox proportional hazards models were used to evaluate the association between hearing loss and incident ischemic stroke, adjusting for CHA2DS2-VASc score.

Results

Among 24,960 AF patients, 90 had documented hearing loss. CHA2DS2-VASc scores were similar between those with and without hearing loss (2.85 ± 1.51 vs 2.63 ± 1.70 , $P=0.238$). Younger patients (<60 years) with hearing loss showed significantly increased stroke risk ($HR 3.42$, 95% CI 1.10–10.68, $P=0.034$). In contrast, older adults (≥ 75 years) with hearing loss had a markedly lower stroke risk ($HR 0.23$, 95% CI 0.056–0.899, $P=0.035$). No significant association was found in the 60–74 group.

Conclusions

Hearing loss exhibits a distinct age-dependent association with stroke risk in AF. Hearing status may therefore serve as an age-specific marker in AF risk stratification and warrants further mechanistic and geriatric-focused investigation.

A112

Addressing code status in older adults in the outpatient setting: lessons learned from a 2-year retrospective study

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Background

Documentation of code status in the electronic medical record (EMR) helps to improve end-of-life experiences but is underutilized(1, 2). The objectives of this retrospective study are to determine the prevalence of documented code status in a geriatric clinic based on the type of visit.

Methods

A total of 495 patients seen from September 2023 to August 2025 met the inclusion criteria. Deceased patients and when code status was addressed in the inpatient setting were removed. Patients were dichotomized into documented code status (DCS) and non-documented code status (NDCS). DCS group involved patients with documented FULL CODE or DNR/DNI (Do not Resuscitate/Do Not Intubate). The NDCS included individuals whose code status were listed as had “See Chart”, “None on file” or “Assume Full Code”. The type of visit was annual wellness (AWV), follow-up and new patient visits. Categorical variables were compared by using chi-square.

Results

Code status was documented in 69 patients (13.9%): average age 83 years old, 56% Females, 70% Whites, 72% Non-Hispanic, 34 patients (49.3%) were documented as FULL CODE and 35 patients (50.7%) were DNR/DNI. AWV was the most common visit to document code status (63 patients, 91.3%). Diabetes was the most prevalent diagnosis (153 patients, 30.8%) Code status documentation was not significantly different in diabetes, major neurocognitive impairment or mild cognitive impairment vs patients without these conditions.

Conclusions

This 2-year retrospective study suggests that annual wellness visits, likely due to the nature of the visit and the designated time for this visit, are the preferred encounter to address and document code status in the outpatient setting for older adults.

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A113

Healthy Aging Through the Senior Years (HATS) Cohort: Brain health among older Black adults

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Background: There is a high prevalence and incidence of later-life dementia among older Black Americans. However, the role of modifiable cardiovascular factors has been understudied. HATS is designed as a companion to the Mayo Clinic Study of Aging with a focus on identification of modifiable cardiovascular and sociodemographic contributions to brain health among older Black adults.

Methods: HATS is enrolling Black Minnesotans from the Twin Cities area aged 55 to 90 years without advanced dementia. Recruitment is primarily community-based and led by three community engagement partners. Our community engagement partners also guide distribution of study results back to participants and the community. Data collection includes medical comorbidities, cardiovascular health, comprehensive cognitive and neuropsychiatric assessments, and informant interviews.

Results: As of December 2025, HATS has enrolled 236 participants (29% male) with a mean age of 68 years (IQR 62-74) and mean education of 14 years (IQR 12-16). Mean BMI is 32 (IQR 26-36), mean SBP is 137 (IQR 124-152), and over half (51%) of participants are current or former smokers. One-third (30%) of participants have diabetes, 74% have hypertension, and 27% have sleep apnea. Many participants (43%) are concerned about their memory, and 21% have objective cognitive impairment on consensus diagnosis.

Conclusion: HATS is a novel longitudinal cohort study that is well-positioned to advance understanding of modifiable risk factors for dementia among Black Americans living in the upper Midwest. Recruitment is ongoing with a focus on enrolling men and participants with a wide range of cardiovascular risk profiles and cognitive function.

A114

Delirium in Older Adults in The Atherosclerosis Risk in Communities Study 2011-2021

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Background: Delirium affects over 2.6 million hospitalized older adults in the U.S. annually. This study describes delirium in a diverse group of community-dwelling older adults that were hospitalized from the Atherosclerosis Risk in Communities study, a longitudinal cohort from 4 U.S. communities. **Methods:** We examine characteristics of patients that experienced delirium during hospitalization. Follow up occurred during in-person study visits, phone calls, and cohort surveillance that reviews hospital stays. Our sample included participants who attended baseline visit 5 (2011-2013), given availability of cognitive data and hospital claims, with at least one hospitalization identified between 2011 and 2021. Delirium prevalence during hospitalizations in the study period was identified from diagnosis codes, using a claims-based algorithm. Delirium prevalence was estimated

as the proportion of hospitalizations in which delirium was identified. Participant characteristics (sex, race, age, frailty, and dementia status) at baseline were described by delirium between 2011 to 2021. **Results:** In this sample of 5,102 participants (mean age 76.3 years, 57.8% female, 23.6% Black), totaling 18,757 different hospitalizations, 795 (15.6%) experienced delirium during at least one hospitalization over the study period. Participants who experienced delirium were older and more likely male. Annual delirium prevalence ranged between 2% and 9%. We found a higher prevalence of delirium among frail patients and those with mild cognitive impairment and dementia. **Conclusions:** These results highlight the burden of delirium in community-dwelling older adults, and those with dementia and frailty. This study examines delirium in a diverse cohort of older adults, enabling us to better investigate the long-term effects of delirium in a more representative group of older adults.

A115

Obstructive Sleep Apnea increases Hospitalizations in Veterans with Heart Failure

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Background

Obstructive Sleep Apnea (OSA) is common in Heart Failure (HF) and may worsen outcomes through intermittent hypoxia and sympathetic activation. Residents of VA Community Living Centers (CLCs) tend to be medically complex with increased prevalence of chronic conditions including HF and OSA. We hypothesized that CLC residents with HF who have OSA experience higher all-cause hospitalization compared to those without OSA.

Methods

We conducted a retrospective cohort study of veterans with HF residing in VA CLCs from 2020–2025, excluding short-stay residents (<100 days). Residents were categorized into two groups: OSA and non-OSA, defined by ICD-10-CM coded diagnoses on T0 defined as the day CLC residents had met the 100-day mark to be categorized as long stay residents. The primary outcome was all-cause hospitalization within 60 days of T0 and secondary outcomes included mean time to hospitalization from T0, amongst others.

Results

The cohort included 6,435 residents with HF, predominantly male (97.1%) with a mean age of 76.3 years. Of these, 2,527 (39.3%) had OSA. Compared with the non-OSA group, OSA residents were younger (73.9 vs 77.9 years). Racial and ethnic distributions differed modestly, with higher proportions of White and non-Hispanic residents in the OSA group. CPAP use occurred in 25.3% of OSA residents. Hospitalization was more frequent in the OSA group (16.4%) than the non-OSA group (12.7%), a 3.7% absolute difference (p<0.001). Mean time to hospitalization was similar: 27.15 days in OSA vs 28.13 days in non-OSA.

Conclusions

OSA increases hospitalization risk in veterans with HF likely due to added vulnerability and its clustering with obesity, hypertension and metabolic disease. These interactions require further studies. Findings support routine OSA screening and integrated management of comorbidities to reduce hospitalizations in this vulnerable population.

A116

Somatic Symptoms in Dementia Care Partners: A Health and Retirement Study Analysis

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Background: Dementia caregiving has long been associated with worse health, and care partners (CPs) describe their health as worse than other's their age [1]. A description of the specific somatic symptoms that dementia CPs experience has not been reported, and an understanding of their actual lived experiences may help us to support their medical needs.

Methods: We used publicly available data from the 2020 cohort of the Health and Retirement Study which surveys a representative sample of ~20,000 US adults. We used the LangWeir datasets to define people with dementia and defined dementia CPs with methods described by Perl, et al [2,3]. Using R and t-tests, we compared CPs to non-CPs, excluding people with dementia. Understanding that older age is a driver of symptom burden, we developed linear regression models controlling for age.

Results: We found that dementia CPs had worse self-rated health as compared to non-CPs. However, dementia CPs reported equal or fewer somatic symptoms than non-CPs (see Table 1). Both of these relationships were maintained when controlling for age.

Conclusion: Our finding that CPs rate their health as worse than non-CPs agrees with prior research. It was unexpected to find that dementia CPs reported fewer symptoms than others their age. It is possible that caregiving is protective for experiencing or noticing symptoms. In the broader literature, there is increasingly described a more complicated relationship between caregiving and health. Further work investigating this dynamic is needed.

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Table 1

Response	t-test: t	t-test: p	CP vs Non-CP (means)	Regression: Coef.	Regression: p	Regression: R ²
Self-rated health	4.386	1.51e-05***	CP = 3.10; NonCP = 2.86 (CP worse)	-0.227	3.05e-05***	0.0027
Satisfaction with health care	-1.744	0.082	CP = 3.09; NonCP = 3.19	0.113	0.049*	0.0018
Persistent lower extremity swelling	-3.073	0.0023***	CP = 3.85; NonCP = 4.25 (CP better)	0.258	0.0027***	0.0077
Shortness of breath	-1.024	0.307	CP = 4.32; NonCP = 4.40	0.059	0.447	0.0036
Fever/diary	-1.509	0.0475*	CP = 4.39; NonCP = 4.54 (CP better)	0.148	0.033*	0.0008
Backache	0.166	0.868	CP = 3.35; NonCP = 3.34	-0.025	0.820	0.00013
Headache	-1.333	0.183	CP = 4.52; NonCP = 4.62	0.141	0.028*	0.0187
Severe fatigue	-2.737	0.0065***	CP = 4.05; NonCP = 4.31 (CP better)	0.267	0.0013***	0.0015
Persistent cough	-2.024	0.0439*	CP = 4.28; NonCP = 4.45 (CP better)	0.153	0.0114*	0.0018

* <0.05, ** <0.01, *** <0.001

A117

Social isolation and service access among older adults living in subsidized housing

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Background: Social isolation among older adults is linked to a variety of adverse health outcomes. Low-income older adults living in subsidized housing are at higher risk for social isolation, which may limit their access to health or social services. This study examines patterns of social isolation and related risk factors over four years among older residents of subsidized housing.

Methods: Data was analyzed from older adults across 94 subsidized housing communities between 2019–2022. Social isolation was assessed using the Lubben Social Network Scale (LSNS-6). Demographic, health, and social-context variables were examined for their association with social isolation using a multivariable mixed-effects logistic regression model on panel data. In longitudinal analyses, we examined patterns in social isolation over time.

Results: Among 8,297 older subsidized housing residents, 48.2% experienced social isolation at least once over the four-year study period. Social isolation was associated with poor self-rated health, lack of transportation, and going without a routine medical checkup in the past 12 months. Longitudinally, about 22% of residents were persistently isolated, 11% were intermittently isolated, 52% were never isolated, and 14% had an unknown pattern due to limited observation. Persistent social isolation was more commonly detected among participants with longer follow-up than among those with fewer years of follow-up.

Conclusion: Social isolation is associated with indicators of poor health and a greater need for support among older residents in subsidized housing. Given these patterns, housing administrators and community partners should engage in sustained monitoring and enhance access to health and social services to help reduce social isolation in this population.

A118

Older Rural Veteran Recovery Experiences after Total Knee, Hip or Spine Surgery

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Background: Accessing resources for post-acute care following surgery can be challenging for older rural Veterans. To understand their experiences and move toward facilitating their desire to recover at home, this study aimed to (1) identify opportunities to improve post-acute care for Veterans recovering from total knee, hip or spine surgery; (2) identify barriers and facilitators to coordinating their post-acute care.

Methods: Twenty-eight older (≥60yrs) rural Veterans and ten discharge planners participated in semi-structured telephone interviews focused on understanding their perspectives and experiences related to post-acute care needs, coordination, and barriers to rural Veterans' recovery at home. The Rural Midwest Veteran Panel provided feedback on the interview guide and sampling strategy. We used qualitative template analysis to analyze interview data by pre-determined domains, further analyzing across interviews to identify cross-cutting themes.

Results. Opportunities identified by participants included (1) preoperative assessment of postoperative care support needs (home environment, transportation, nutrition, family/community) to proactively install safety recovery equipment (grab bars) and plan post-surgical coordination of physical therapy as well as identified support needs; (2) recovery education (e.g., pain, anticipated time they would be "laid up" with immobility) and activities to promote recovery. Veterans most commonly identified mobility challenges, including falls (n=2), when discussing complications while recovering at home. Interview data revealed discharge planners searched "outside the box" to meet older rural Veteran needs. Older rural Veterans displayed an underlying resilience and adaptability that influenced their willingness to bear certain challenges, such as distance (mean miles to surgical VA hospital: knee=83.3; hip=67.5; spine=107.8), to achieve the desired pain relief and return of mobility from total knee, hip, or spine surgery.

Conclusions: Older rural Veteran discharges are complex and require creativity to orchestrate. The time to figure this out is before, not after, surgery. Older rural Veterans will benefit from comprehensive assessment, education, and coordination of post-acute care needs to optimize home-based recovery post-surgery.

A119

Healthcare Providers' Insights on Social Engagement's Barriers and Facilitators Among Homebound Older adults

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Background: Being homebound and having multiple chronic conditions (MCC) predispose older adults to high risk for social isolation and loneliness. About 4 in 10 individuals with MCC report being socially isolated, including endorsing a lack of companionship, feeling left out or lonely. Homebound older adults with MCC are at increased risk for chronic stress, frailty, and experience poor health outcomes and quality of life, which could hinder their ability to participate in social activities and limit their social relationships. Healthcare providers can play a key role in identifying and addressing barriers to social engagement while promoting facilitators to improve social engagement. However, there is very limited evidence on healthcare providers' perspectives on the importance of social engagement in homebound older adults with MCC. The qualitative study aimed to gain more in-depth understanding from healthcare providers' perspectives of the factors enabling and impeding social connections in homebound older adults with MCC.

Methods: We conducted semi-structured interviews with 18 healthcare providers including physicians, nurse practitioners and case managers, recruited from different institutions in New York between August 2024 and May 2025. The interviews pertained to their input on the importance of social engagement, potential barriers and benefits regarding technology-based social interventions, and strategies for social engagement.

Results: Using a direct content analysis approach, six themes were identified, including support systems, community resources, technology solutions, personalized social engagement strategies, physical and environmental barriers, and technology-related barriers.

Conclusions: The findings of this study reveal the salient role played by social engagement in homebound older adults with MCC and the importance of integrating healthcare providers' insights in order to design effective interventions and shape policies to support social engagement in homebound older adults with MCC.

A120

Documenting patients' life stories in long-term care – an adaptation of My Life, My Story

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Background: My Life, My Story (MLMS) is a successful VA program that uses narrative medicine to enhance insight into personhood and support patient-centered care. Although narrative medicine programs have shown benefits in other settings, evidence on how to implement them in long-term care, especially in ways that do not exclude residents with cognitive disorders, remains limited. We conducted a pilot study in a long-term care unit at a large academic facility, adapting the VA MLMS model as part of institutional adoption of the Age-Friendly Framework. Life story interviews were used to capture what Matters Most to patients.

Methods: Residents were identified by admission date, beginning with the most recent admissions. If patient was unable to provide information, their healthcare proxy (HCP) was approached; they were excluded if not interested or unavailable. The VA MLMS interview guide was adapted, and Matters Most questions were incorporated. Stories were typed from interview notes, and a printed copy was provided to each resident. Feasibility outcomes included the proportion of residents with a completed story, the proportion requiring HCP support, the time taken to complete and transcribe interviews, and the

ability to upload stories into the electronic medical record (EMR). Data were summarized descriptively.

Results: Twelve residents were approached; 10 completed a story. Among these, mean age was 78, and 60% were female. Four had confirmed cognitive disorders. Three residents were unable to communicate verbally: one relied on the proxy, one used eye-tracking technology (Tobii device), and the other typed on a personal tablet. All stories were reviewed by the resident or HCP, edited as needed, uploaded into the EMR, and assigned a new 'Life Story' label to improve visibility. We could not complete stories for two patients - one deferred; another had behavioral symptoms of dementia, and the HCP could not be reached. Most interviews were completed under 30 minutes, with additional 30 minutes for editing, reviewing, and uploading.

Conclusion: Narrative medicine interviews are feasible in long-term care, even among residents with cognitive disorders. Next steps include expanding this framework across the facility, integrating this tool to support Matters Most conversations.

A121

Understanding Values of People Living with Dementia to Advance Person-centered Care: Insights from Care Recipients and Caregivers

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Background: Caregivers can experience ethical conflicts when people living with dementia express care preferences that conflict with values care recipients previously espoused. Little is known about processes of valuing in dementia, impeding efforts by healthcare professionals to support families in making value-aligned care decisions. This study explores the feasibility of asking people with dementia about their values, how care recipients express values, and caregiver perceptions of value continuity and change.

Method: We recruited dyads from the Fein Memory & Aging Center clinic and two UCSF dementia studies. In ethnographic interviews, we asked care recipients in early stages of dementia about the important people, places, and events in their lives in the presence of caregivers. In a private interview, we asked caregivers to reflect on care recipient interviews. We audio-recorded and transcribed interviews and developed insights through iterative review and discussion.

Results: We interviewed 14 dyads: frontotemporal dementia (n=9) and Alzheimer's Disease (5). Most care recipients highlighted sustained involvement in important pursuits and relationships, but one shared a new ethical commitment. Caregivers noted alignment between care recipient reflections and their understanding of care recipient values. Caregiver narratives of value continuity and change varied; caregivers cited value "distortion," intensification of values, emergence of challenging behaviors that both aligned and misaligned with current values, and declining ability to articulate values in language. Some caregivers could imagine invoking a care recipient's values to reorient them away from difficult behaviors or promote well-being.

Conclusions: Care recipients and caregivers often report value stability, but changing expression of values is not uncommon. Our study demonstrates the feasibility of discussing values with people with dementia. Personal values undergird one's sense of self, and clinicians' understanding of care recipient value change and continuity can inform person-centered dementia care and caregiver support.

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A123

Post-Intensive Care—Transitional Care, Rehabilitation, and Family Support (PIC-TRFS): A Theory-Driven Model of Community Reintegration After Critical Illness

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Background: Theories of change (ToC) explain how and why desired outcomes are expected to occur in a particular context; intervention models operationalize theories into concrete processes for achieving change. We sought to develop a ToC for returning to mainstream community and family life roles (“community reintegration”) in the context of critical illness-related disability, and applied it in an intervention model.

Methods: Using participatory methods, we co-developed a ToC describing processes (“how”) that facilitate and mechanisms (“why”) of community reintegration. We translated its theoretical hypotheses into a testable intervention model, which we refined in a feasibility pilot study (n=21 dyads).

Results: PIC-TRFS ToC has 4 hypotheses: 1) Social care increases self-efficacy and community reintegration by helping patients and families learn new health behaviors; 2) Rehabilitation increases self-efficacy and community reintegration by developing transferrable skills for self-selected activities; 3) Access to community resources improves community reintegration; 4) The strength of relationship between the participants and interventionists enhances community reintegration.

To operationalize these hypotheses, the PIC-TRFS intervention model integrated 3 evidence-based approaches: 1) the Patient Priorities Care model to align care with patient goals and support goal-directed behavior change; 2) Strategy Training to build transferrable skills for self-selected activities; 3) the Transitional Care Model to assess needs and coordinate healthcare and community resources.

The pilot study results led us to refine the intervention model by: 1) shifting emphasis from medical to social prescribing; 2) revising patient-facing materials to better support behavior change; 3) adopting a lighter-touch, longer-duration format; and 4) simplifying measurement.

Conclusions: PIC-TRFS is a theory-driven intervention designed to promote positive coping and community reintegration after critical illness. Its efficacy is being evaluated in a randomized control trial (NCT06501365).

A124

Perspectives on Medication Use Among Aging World Trade Center Responders

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Background:

Responders from the World Trade Center (WTC) disaster rescue and recovery service who were exposed to 9/11 environmental toxicants over two decades ago have increased risks for chronic health conditions and polypharmacy. Responder experiences and concerns with aging and medication use are important considerations in their healthcare, yet their perceptions are relatively unknown. This project aimed to obtain responder insights on medication use in order to design interventions that promote optimal medication use and limit polypharmacy.

Methods:

We enrolled WTC responders from various occupations, ethnicities, and frailty levels, ≥ 50 years from the Mount Sinai and Rutgers

University clinics. We used topic guides in semi-structured interviews to learn about responders’ concerns on aging and medication use. Interviews done January to August 2025 were recorded and transcribed. We implemented rapid qualitative analysis to identify core themes related to medication use.

Results:

Responders (n=30, 15 Mount Sinai, 15 Rutgers, 33% women) aged 51-84 years (23% in 6th decade, 47% in 7th, 20% in 8th, 10% in 9th) from different occupational groups (37% protective services, 33% trades, 30% volunteer/other) and backgrounds (67% White, 20% Black, 10% Asian, 3% other) reported taking multiple medications and generally accepted it as a normal, necessary aspect of aging. Across the groups, participants were concerned about side effects, large number of medications, potential interactions and long-term use and desired discussions regarding both WTC and non-WTC related medications, yet with varying opinions with which provider, a WTC or non-WTC affiliated clinician. Many had a preference for minimizing medications due to worries about risks, yet some had interest in additional vitamins and supplements.

Conclusion:

WTC responders report medication use as a necessity in aging, though with many worries about increasing polypharmacy and negative medication effects. Many desired in-depth clinician discussions about those effects as well as medication indications, potential medication decrease or alternate options. Through better understanding of responder perspectives interventions can be tailored to address their specific concerns, optimize medication use, and limit polypharmacy risks as responders age.

A125

Hospice Staff Reflections on Implementing NOVELA Videos in Hospice Care

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Background: NOVELA is a video-based educational intervention that shows a promise in enhancing caregiving preparedness, understanding of care recipient illness and finding emotional support in hospice care. However, it’s successful integration into clinical workflows depends on hospice staff engagement and perceptions of feasibility. This study aims to explore hospice staff’s perceived barriers and facilitators to implement NOVELA in hospice care.

Methods: We conducted semi-structured interviews that were recorded, transcribed, and analyzed thematically to identify strategies for integrating NOVELA into hospice care. The study involved hospice staff from Mid-Atlantic, Caribbean, and Southern United States representing a diverse interdisciplinary roles including physicians, nurses, social workers, chaplains and administrators.

Results: The sample was predominantly female and White, with a mean age of 51.7±9.6 years and a mean of 10.5±8.8 years of hospice experience. Most participants had attained education beyond college. Preliminary analysis identified several facilitators and barriers to integrating NOVELA into routine care. Facilitators included intervention’s alignment with staff values and its ability to enhance caregiver understanding and improve communication with healthcare teams. Barriers included workflow disruptions, limited caregiver access to technology, and the timing of NOVELA’s introduction during admission.

Conclusion: Hospice staff responded favorably to implementation of NOVELA, perceiving it as an impactful intervention that could strengthen caregiver education in hospice settings. Successful adoption requires integration into existing routines and alignment with caregiver’s needs and timing.

Hospice Staff Sample Characteristics

Variable	Hospice Staff (n=20)
Age in years, mean $\pm$ SD	51.63 $\pm$ 9.62
Sex, n (%)	
Male	7 (35%)
Female	13 (65%)
Ethnicity, n (%)	
Hispanic or Latino	9 (45%)
Not Hispanic or Latino	11 (55%)
Race, n (%)	
White	12 (60%)
Black or African American	1 (5%)
Other*	7 (35%)
Highest Education, n (%)	
College	9 (45%)
More than college	11 (55%)
Profession / Field of Training, n (%)	
Nurse	2 (10%)
Physician	3 (15%)
Chaplain	3 (15%)
Social Work	4 (20%)
Other**	8 (40%)
Years Profession After Training (Range of years)	10.49 $\pm$ 8.76

*Other race: Mixed (n=1), Latino (n=2), Puerto Rican (n=2).

**Other profession: director of quality (n=2), administration (n=2), bereavement counselor (n=1), human resources (n=1), supervisor of supplies (n=1), healthcare aid (n=1).

A126

Approach to Pain Management After Surgery for Older Adults: A Qualitative Study

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Introduction

Post-operative pain management has become increasingly complex in recent years as surgeons focus more on multimodal pain management, using medications such as acetaminophen, non-steroidal anti-inflammatory drugs and gabapentin in addition to opioids. Despite the importance of pain management for recovery and the risks posed by pain medications, little research explores how patients navigate increasing complex, multimodal post-operative pain regimens. This study aims to describe how older adults approach their pain management after surgery.

Methods

This qualitative study used in-depth interviews focused on exploring how patients approach pain management once home after surgery. Eligible participants were ≥ 65 years old, had been hospitalized after major surgery within the last three years, and had mild to no cognitive impairment. Interviews were completed after the patient had been discharged home, and caregivers were included when available. Interviews were analyzed with thematic analysis to identify themes with approaching pain management at home after surgery.

Results

Seventeen older adults (53% White, 59% women, average age 73) and 4 caregivers were interviewed. Patients and caregivers endorsed three main approaches to managing their pain medications: strict adherence to physician instructions, proactive decision-making about medication use, and making uncertain decisions without clinician guidance. See Table 1 for representative quotes.

Discussion

Challenges abound for older adults in managing and understanding the use of postoperative pain medication after discharge from the hospital. However, most of these challenges are addressable through targeted patient education, which could be tailored to address the style of decision-making exhibited by different patient types.

Close adherence to physician instructions	"Interviewer: How did you decide when to stop taking the pain medication?" Respondent: It was set up that way. They told me not to go more than two weeks. It was whatever was in the doctor's orders when I left the hospital...The plans were well-written. I tried to follow it exactly like they had." Patient 17
	"Keep a diary or a log what your daily routine should be, and follow it to the T. And if it doesn't work, go back to your doctor and ask again what else could I do... You should follow your doctor's orders. And if you don't trust your doctor, change doctors." Patient 1
	"I don't ask anything. They offer me all kind of things. I took so many things. I don't know what they give. I just obediently take whatever they give to me." Patient 8
Proactive decision-making regarding medication use	"I read quite a bit, and I research on my own. So, I'm well aware of what's going on with pain medications, opioids. I understand the ramifications, and I try to be very proactive in my care. I will not take anything that I don't know what it's for. When I was at the hospital, every time they gave me a container with pills, I make sure I know what each one is for. And if I didn't [know], I wouldn't take it until somebody tells me." Patient 10
	"When I went to leave the hospital, things were explained to me. I said I knew that this wasn't going to work for me because of how much pain I was in. So, they worked with me, I told them what I wanted and what I was going to do, because I wasn't going to come home and have to take Tylenol-3, because that wasn't going to work." Patient 9
	"[I stopped oxycodone because] I thought it was not helpful. I could not tell that it did anything, much for my pain. It maybe took a little edge off of it, but didn't resolve my pain. But it did have side effects. And so, I felt the side effects outweighed the benefit of it." Patient 11
Making uncertain medication decisions without clinician guidance	"It was like take care of yourself, basically. This is what we're going to give you and if you need more call. When I got home, it was up to me to titrate off and not get hooked up." Interviewer: And how did you do that? Patient: I just do it. I just go down to where I could handle it without, so then I just cut it." Patient 16
	"They give you a number of items, that sometimes you don't even know what they are for. You are not told this will do this, and that will do that." Patient 2
	"They ordered [an opioid] but I didn't take it. I don't know why that time I decide[d]. They send it to me. They say something. I thought I'm allergic to it. It seems I only took gabapentin, the rest I didn't. You think all those would help me more? I would be much better now?" Patient 6

A127

Behind the Mic: Lessons Learned from Developing Geriatric Fast Casts (Podcasts)

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Background: Podcasting is an increasingly popular medium for medical education. Despite growth in listeners and available content for clinicians (eg, GeriPal, GEMCAST), there remains gaps for <25-minute geriatrics focused podcasts. To address this gap, we developed *Geriatric Fast Casts*, a < 10-minute geriatrics micro-podcast for interprofessional learners. This project aimed to identify best practices for podcast creation.

Methods: A needs assessment was performed to identify target topics, audience, and format. *Geriatric Fast Casts* launched in March 2025, publishing 1-2 episodes per month. After publication of each episode, the team conducted semi-structured debriefs to evaluate process and content quality. Iterative refinements for topic selection, outline creation, guest orientation, recording, editing, publishing, and dissemination were integrated into subsequent episodes with a continuous improvement framework.

Results: *Geriatric Fast Casts* episodes have been downloaded >500 times in <7 months. Team debrief analysis yielded lessons from 7 major domains. See Table 1.

Conclusion: Creation of an educational micro-podcast is a feasible approach to disseminating geriatrics educational content. Employing key strategies can ensure higher quality educational content while decreasing resource requirements.

Table 1

Domain	Lessons Learned
Topic Selection	- Identify gaps through stakeholder interviews
Outline Creation	- Create an outline, avoid a script, to encourage a conversational tone. - Use AI to assist with script creation using human supplied target material
Guest Pre-orientation	- Meet with guests. Discuss target audience, podcast length, and editing capabilities. - Review outline and finalize
Recording	- Utilize a podcasting platform to create a virtual studio for ease of recording - Keep the video on so guest and host can see audience reaction in real time
Editing	- Generate a transcript from the audio file to facilitate editing - Employ free audio editing software that is user-friendly for novices
Publishing	- Use a podcasting host site to distribute to major podcast listening platforms (i.e. Apple podcasts, Spotify, iHeartRadio)
Dissemination	- Encourage subscription/follows on podcast platforms to increase early listens. - Publish episodes regularly to ensure ongoing listener engagement - Utilize analytics to determine most popular podcasts and analyze

A128

Asynchronous Geriatric 5M's Mini-Course to Enhance Knowledge and Skills in Ambulatory Residents' Care for Older Adults

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Background: The ACGME reduced the geriatric education requirements for Internal Medicine (IM) residents in 2022, yet there is a known increase in need for geriatrics care. This study aims to assess the effectiveness of an asynchronous mini course that residents could use to improve their care of geriatrics patients.

Methods: PGY1 residents at an academic medical center were asked to complete a mini course and pre/post surveys during their first two clinic weeks. PGY3 residents were asked to complete the course and the surveys during their Geriatrics elective. Geriatrics fellows were asked to complete the course and the surveys during the first week of fellowship. The mini course includes videos discussing each of the Geriatrics 5Ms.

Results: Please see attached table

Conclusions: This course was instituted with the goal of assessing where the residents' knowledge was related to the 5Ms prior to the mini course and standardizing content learned for all residents going forward. When comparing the presurvey to post survey responses, there is a noted overall increase in correct responses to knowledge questions for both PGY1s and PGY3s/geri fellows. It was not a robust response rate, but we can compare trends to help guide next steps which include in person didactic/case-based sessions and note auto-texts to help address these issues with all patients. We also recognize that a one-time session may not yield long term knowledge improvements and repetition through other formats at future times is needed.

Resident Pre and Post Survey Responses

	PGY1 Pre-test	PGY1 Post-test	Gen Elective/Gen Fellow Pre-test	Gen Elective/Gen Fellow Post-test
# of responses	13	10	14	8
Correctly listed 5Ms (% responses)	4 (31%)	8 (80%)	5 (36%)	8 (100%)
Correctly name 2 Depression Screening Tools for Geri patients	2 (15%)	6 (60%)	3 (21%)	6 (75%)
Correctly name 3 Cognitive Screening Tests	2 (15%)	8 (80%)	6 (43%)	8 (100%)
List at least 2 risk factors for falls	9 (69%)	9 (90%)	13 (93%)	6 (75%)
Correctly identify high risk meds	3 (23%)	6 (60%)	8 (57%)	6 (75%)
Correctly identify frailty characteristics	8 (62%)	8 (80%)	9 (64%)	6 (75%)
Confidence in Deprescribing:				
Very Comfortable (%)	1 (8%)	0 (0%)	2 (14%)	2 (25%)
Somewhat Comfortable (%)	4 (31%)	7 (70%)	8 (57%)	5 (63%)
Somewhat Uncomfortable (%)	6 (46%)	3 (30%)	4 (29%)	1 (13%)
Very Uncomfortable (%)	1 (8%)	0 (0%)	0 (0%)	0 (0%)
Confidence in discussing what matters most:				
Very Comfortable (%)	3 (38%)	4 (40%)	4 (29%)	4 (50%)
Somewhat Comfortable (%)	6 (46%)	6 (60%)	9 (64%)	4 (50%)
Somewhat Uncomfortable (%)	1 (8%)	0 (0%)	1 (7%)	0 (0%)
Very Uncomfortable (%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Confidence in taking care of Geriatrics patient:				
Very Comfortable (%)	0 (0%)	0 (0%)	5 (36%)	4 (50%)
Somewhat Comfortable (%)	9 (69%)	8 (80%)	7 (50%)	4 (50%)
Somewhat Uncomfortable (%)	3 (23%)	2 (20%)	2 (14%)	0 (0%)
Very Uncomfortable (%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

A129

Tennessee Dementia ECHO: Expanding Access to High-Quality Dementia Care through Education of Community Care Partners

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Background: Comprehensive care for cognitively impaired adults is increasingly challenging in primary care. A rapidly evolving landscape of biomarkers, diagnostic tools and novel medications can result in missed treatment opportunities. The TN Dementia ECHO program seeks to educate and re-invigorate the dementia care workforce in early diagnosis, treatment, and management of neurodegenerative disorders.

Methods: A virtual course was advertised by email among primary care groups across TN. The course met virtually over 12 weekly recorded sessions. CME credits were offered. Session

objectives were written by each content expert. Pre and post-session surveys were administered virtually using Likert style questions (1=least confident, 100=most confident) to assess participant self-confidence in the outlined session objectives. The project was funded by the TN Dept of Health.

Results: Between June 2024 and November 2025, the program delivered 24 interactive sessions, enrolling 560 unique learners, representing >40 learning sites statewide. On average, 7 learners attend each session. Learners serve urban (30%), suburban (14%), rural (47%), and tribal (1.2%) communities. 61 participants completed surveys. 36 participants were primary care practitioners, and 25 participants were additional care partners (psychology, therapy, nursing and social work domains). Self-rated confidence increased among several categories, including screening for cognitive impairment, complex medication decisions, and medication optimization (independent t-test, t = 11.01, p < 0.000001), indicating a highly significant improvement in confidence following participation.

Conclusions: The virtual, highly accessible, ECHO classroom format where "all learn, and all teach" demonstrates promise in improving knowledge and confidence with dementia care. Participants reported increased knowledge and were able to bring challenging cases for real-time discussion with a panel of experts. Standardized evaluation tools are needed to assess the long-term impact of ECHO participation in diverse healthcare settings. Long-term clinical outcomes were not assessed; this is a potential area for future research. Integrating geriatric and dementia focused ECHO programs into workforce development initiatives can strengthen care capacity, especially in rural and underserved communities and support equitable access to high-quality care.

A130

The Impact of Narrative Medicine on Future Physicians

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Background: When caring for older adults, physicians too often focus on their diseases with limited extension beyond the medical domain. In our medical student curriculum, we emphasize a person-centered holistic and humanistic approach to care that is aligned with "what matters most" to the patient, one of the 4 M's of an Age Friendly Health System. In this study, we evaluated student reflections on a "Patient Story" narrative medicine assignment they completed with an older adult patient that exemplifies this approach.

Methods: During a required geriatric rotation in our Practice of Medicine Clerkship, students interviewed an older adult patient to learn about their story, meaningful lived experiences, and what matters most to the patient - information beyond what they typically elicit during the social history. Then they wrote up this narrative and submitted a 1-2 paragraph reflection on the experience. We conducted an AI-assisted thematic analysis of 623 student reflections using NotebookLM to provide the themes and sub-themes that were subsequently reviewed and refined by the researchers.

Results: We identified four major themes. Theme 1: A transformative perspective of seeing the "Whole Person" which included the subthemes of seeing the patient beyond the medical record and challenged pre-conceived notions and biases. Theme 2: The importance of prioritizing patient values and goals of care with what matters most as a guiding principle as well as insights gained about the import of non-medical issues (family, autonomy and independence, having a purpose). Theme 3: The value of time, listening and human connection with students. Theme 4: The impact on professional identity and personal growth with the patient encounters reaffirming students' motivation for medicine, solidifying their commitment to integrating a more holistic approach in their future practice, and fostering the acquisition of wisdom from the older adults they interviewed.

Conclusions: The thematic analysis of reflections revealed profound shifts in medical students' perspectives on patient care, professional identity, and personal values. The experience reinforced the value of humanistic care over a purely clinical focus and showed that narrative medicine can be a valuable addition to the traditional medical school curriculum to foster this humanism.

A131

Beyond Discharge: Enhancing Resident Education on Skilled Nursing Facility Transitions

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Background: Effective transitions of care from hospital to skilled nursing facilities (SNFs) are essential for ensuring patient safety, continuity of care, and optimal health outcomes. Despite the importance of these transitions, medical education frequently lacks training on safe and effective handoffs to SNFs, which can lead to medication errors and preventable rehospitalizations. We investigated the impact of an immersive SNF educational experience amongst Internal Medicine (IM) residents.

Methods: PGY-1 IM residents participated in a structured educational experience focused on transitions of care to SNFs. Over an 8 week period during the IM 2 week ambulatory blocks, 11 groups (5-6 residents each) completed a SNF teaching tour at a community SNF staffed by Penn Geriatric faculty. The session included a focused discussion on appropriate SNF discharges, available interdisciplinary resources, and best practice documentation, followed by a 20-minute tour comparing SNF and long-term care settings, and meeting members of the interdisciplinary team. Residents also reviewed discharge summaries, evaluating strengths and identifying gaps. To evaluate the sessions' impact, 4 of the 11 groups completed a pre- and post-session survey measuring confidence and knowledge related to SNF transitions.

Results: Out of 22 PGY-1 IM residents, 36% had prior experience either visiting or providing care in a SNF or long-term care setting, with only 22% having done so during their medical education. For 14 residents, this was their first direct exposure to patient care in a SNF or long-term care environment. Following the education session, 59% of residents reported improvement in knowledge of identifying patients appropriate for SNF, 72% felt more confident in identifying specific skilled services available in SNFs, and 95% felt more confident in ability to identify and prevent common errors during the discharge process.

Conclusion: This educational experience improved resident preparedness for safe SNF transitions but its one-time nature may limit long-term impact. Ongoing training either in the hospital or through a longitudinal component can reinforce skills and support sustained competency. Adding Family Medicine and other primary care areas would also broaden trainee benefit.

A132

Bridging the Gap: A Delirium and Dementia Curriculum for Internal Medicine Residents

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Background: Delirium is associated with adverse outcomes including functional decline, falls and cognitive impairment.¹ Incident hospital delirium may persist in up to 45% of patients at discharge and 33% at one month.² Care for these patients is often delivered by primary care physicians (PCPs) who report inadequate training and experience.³ To inform curriculum development, we conducted a needs assessment of resident and PCP experience and confidence caring for older adults with delirium and dementia. **Methods:** We performed a literature review of geriatric core competencies and an expert review involving specialists in geriatrics, delirium, and dementia to identify key domains. An anonymous online survey was

administered to PCPs and internal medicine residents at an academic medical center (2023-2024) to assess outpatient experience and confidence in delirium and dementia care. Based on identified gaps, we developed interactive online educational modules for residents. A post curriculum survey is ongoing to assess changes in confidence and clinical experience. **Results:** Seventy-four participants responded (34% response rate). Sixty-five respondents (88%) reported addressing cognitive concerns in older adults only sometimes or rarely in primary care. Seventy (95%) reported addressing post hospitalization delirium sometimes, rarely or never. Twenty-four (33%) and thirty-nine (53%) reported limited confidence administering dementia and delirium screening tools, respectively. Participants also reported low confidence in care planning, prognosis discussions and medication management. **Conclusions:** Internal medicine residents and PCPs reported limited confidence in outpatient screening and management of delirium and dementia. Given the rapid growth of the population aged >80 years, these findings highlight gaps in residency training. We developed an online curriculum to address these needs, with future expansion planned for continuing medical education.

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A133

Implementation of a transitions of care curriculum and clinical experience for geriatric medicine fellows

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Background: Older adults are especially vulnerable during post-acute care transitions. Hospital-based co-management models focus on optimizing acute care, but rarely integrate across institutions. Similarly, resident and fellow curricula often do not incorporate skills needed for optimal care transitions. We sought to create a clinical rotation and didactic series in the post-acute care setting to increase geriatric medicine fellows' confidence in facilitating effective care transitions.

Methods: Two geriatricians performed a structured needs assessment to identify specific knowledge gaps and relevant transitions of care curricular topics for geriatric medicine fellows. Trainees completed a 4-week clinical rotation supervised by a geriatrician. Learners participated in structured weekly didactic sessions and one-on-one teaching about specific care transitions domains in addition to providing clinical care at a post-acute care facility. Each trainee completed a pre- and post-rotation survey that assessed fund of knowledge, confidence using a Likert scale (1 extremely unconfident to 5 extremely confident) and qualitative responses.

Results: Seven care transitions domains not explicitly covered in the existing fellow curriculum were identified by the needs assessment. Between September 2022 and May 2024, 10 geriatric medicine fellows completed the post-acute care elective. Before the elective, 20% reported above average knowledge about care transitions, while 100% reported above average or excellent knowledge (4 or 5) afterwards. Fellows also reported increased confidence in all the targeted care transitions domains (Table 1).

Conclusions: Transitions of care is an unmet educational need for geriatric medicine fellows, who receive limited experience in the post-acute care setting during fellowship. This 4-week post-acute care clinical rotation with targeted transitions of care education substantially increased geriatric medicine fellows' confidence and knowledge in care transitions.

Fellow confidence before and after the care transitions elective

Care Transitions Domain (confidence on a Likert Scale 1-5)	Pre (n=10)	Post (n=10)	change	% confident pre	% confident post
Create a post-rehab discharge plan	3	3.9	0.9	20	80
Familiarity with community resources	2.7	3.7	1	n/a	n/a
Identify threats to a safe care transition	3.4	4.2	0.8	50	90
Anticipate consequences of a poor care transition	3.7	4.4	0.7	60	100
Assess changes in functional status	3.2	4.2	1	30	90
Compile pre- and post-hospital medication records	3.7	4.4	0.7	60	100
Evaluate medication discrepancies	3.7	4.5	0.8	60	100
Overall	3.34	4.19	0.84	46.67	93.33

A134

Implementation of a Geriatrics rotation for visiting residents

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Background

The older adult population is the most rapidly growing age demographic in the United States. By 2030, 21% of the US population will be >65 years of age¹. As this population grows, so does the need for Geriatricians. Recruitment of trainees can be challenging. Fifty-six percent of Geriatric fellowship positions went unfilled in 2025, and half of all positions go unfilled annually². Contributing factors include earning potential, student loan debt, and burnout. Further, virtual interviews limit program visits, hampering ability to determine if fellowship is a good fit.

We created a rotation for visiting residents to:

1. Give access to training in care of older adults from Geriatricians and Geroscience.
2. Increase exposure to Geriatric Fellowship opportunities.

Methods

We developed a clinical rotation in Geriatric Medicine specifically for visiting residents. Each rotation exposes residents to interdisciplinary care in primary care, inpatient consultation, skilled nursing rehabilitation and long-term care. Didactics, morbidity and mortality, journal club, and ethics conferences are included. At the end of the rotation, a feedback survey is completed.

Results

Since 2024, three visiting residents have completed the rotation. 100% of participants did not have a Geriatrics Division and one third did not have a Geriatrician at their institution. All felt more confident in polypharmacy and deprescribing, cognitive assessment, delirium evaluation and management, and transitions of care. All reported being very likely to pursue a career in Geriatrics. Of the three, one has matched into our fellowship, and another has match results pending.

Conclusions

Care of older adults is part of residency education yet not all have access to Geriatricians. Offering a rotation for visiting residents increases Geriatrics exposure and knowledge. Additionally, a rotation serves as a successful recruitment opportunity for fellowship.

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A135

Mutual Learning in a Veterans Affairs Dementia Conference

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Background: Healthcare professionals working in direct patient care settings have valuable knowledge and ideas to share regarding dementia care, and also need opportunities to enhance and update their dementia knowledge and skills. We sought to understand the role of mutual learning in dementia education.

Methods: Veterans Integrated Service Network 8 (VISN 8), a regional network in the U.S. Department of Veterans Affairs, presented a full-day virtual conference for staff members on dementia etiologies, risk factors, diagnosis, and multidomain care. Participant interactions and discussions were emphasized to deepen the understanding of these topics. A test of dementia knowledge was taken by participants prior to and after the conference. Paired t-test was used to compare the mean pre-test and mean post-test scores. After a brief presentation on pertinent findings of HERO CARE, a multi-VISN survey of Veterans and their caregivers, conference participants were also asked to complete a brief intra-conference survey based on those findings and to offer ideas on how to optimize dementia care services in VISN 8. The final activity was a post-conference evaluation of the learning experience.

Results: The conference had 299 participants including registered nurses, social workers, physical therapists, psychologists, speech pathologists, pharmacists, advanced practice providers and physicians. 121 participants completed the knowledge test both prior to and after the conference. The mean pre-test score was 42%, range 0%-100%, which improved to 60% post-test (range 20%-100%), p-value <0.001. 86 participants completed the intra-conference survey regarding optimization of dementia care, and their ideas will be integrated in service planning. Many of the participants' suggestions pertained to the scope, timing, format and advertising of caregiver education. 99% of the 192 participants who completed the conference evaluation indicated that the, "educational activity advanced (their) knowledge, attitudes and skills...."

Conclusions: Mutual learning techniques in interprofessional conferences may enhance dementia knowledge and optimization of dementia care.

A136

The Effect of the NEAT Program on Nursing Students' Aging Knowledge and Geriatric Care Competencies: A Pre-Post Pilot Study

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Background:

The Riverside Health Systems (RHS) Nurse Extern Advancement Training (NEAT) program is a geriatric education initiative placing Bachelors of Nursing Students in a geriatric externship. Its primary goal aligns with Health Resources and Services Administration Geriatrics Workforce Enhancement Program objective to develop reciprocal partnerships between academia, primary care sites/delivery systems (including nursing homes), and community organizations, to transform clinical training environments into integrated geriatrics primary care sites/delivery systems that are age-friendly and dementia-friendly. The NEAT program was developed and delivered for the first time in summer 2025. One learning objective was to enhance the students' aging knowledge.

Methods:

The students' aging knowledge was assessed using the Aging Quiz, a 50-item questionnaire to measure basic knowledge of physical, mental, and social facts about aging, expose common misconceptions, and evaluate the effectiveness of educational interventions related to aging before and after the program. The McNemar test was used to assess aging knowledge changes.

Results:

A total of 23 students participated in the 6-week NEAT program in summer 2025. Participants represented a range of rural and underserved RHS facilities, including Acute Care, Medical Group Offices, and Lifelong Health & Aging services. Due to partial missing data, analyses were conducted on available paired responses (n=19). Results indicated that 25 items on the Aging Quiz showed an increase in correct responses following program participation, four items remained unchanged, and 21 items demonstrated a decrease in correct responses. There were no statistically significant differences between pre- and post-program scores.

Conclusion and Future Directions:

Although the results are not statistically significant, there are relevant pedagogical implications for creating didactic opportunities for nursing students in geriatrics. After the 6-week externship increases in aging knowledge was only demonstrated for 50% of content measured and more than 40% of items had a knowledge decrease. There are several potential explanations for this, including a misalignment between the curriculum and the Aging Quiz. This work highlights the importance of identifying the geriatric education gaps in curriculum.

A137

Caregiver Conversations about Dementia Primary Care: a novel activation strategy

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Background: Primary care of dementia is essential but varies in quality. Clinician education is needed but caregiver activation can be an important adjunct. Caregiver requests can improve the quality of geriatric care in general (Maly RC et al. Arch Fam Med 1996). Utility of this approach in ADRD primary care is unknown. Accordingly, this report is an initial assessment of "Caregiver Conversations about Dementia Primary Care" (CC), that examines feasibility, acceptability, and knowledge gains.

Methods: Via a preliminary survey, an interprofessional team documented knowledge of good dementia health care and how to ask questions aimed at receiving this care as critical CC learning domains. Caregiver management of ADLs and locating resources were also noted as topics of interest and added to meet audience learning needs. CC programming thus consisted of 2, hour long sessions. Change in self-rated knowledge of the 4 content domains was assessed by pre-post-polls at each session using a 4-point Likert scale 1-poor--4-excellent. Pairwise and independent Wilcoxon signed rank tests assessed the magnitude of mean knowledge gains in each domain.

Results: Over 4 CC series (each 2 sessions), 107 participants attended at least 1 and 87% attended both. Participants were predominantly older Caucasian women residing in urban Virginia and 28% identified as healthcare professionals. Participant feedback overwhelmingly noted that CC sessions delivered useful information from knowledgeable presenters. Significant knowledge gains were noted for 3 of 4 domains (see Table).

Conclusion: CC is feasible; it can recruit and sustain an audience. CC was well-received, documenting acceptability. CC led to knowledge gains with both paired and independent analyses finding significant knowledge improvement in 3 of 4 content domains. Future work should remove or revise caregiver ADL content, consider shorter sessions, broaden demographic participation, adapt programming to the needs of professional caregivers, and ultimately, examine CC's impact on caregiver satisfaction with care and other quality outcomes.

CC pre-post knowledge gains

	Knowledge ADRD care**	Asking questions*	ADL care**	Resources**
Unpaired	2.40 => 2.79 (+0.39); P<0.009	2.72 => 3.00 (+0.28); P<0.002	2.72 => 2.9 (+0.18); p<0.06	2.23 => 2.92 (+0.69); P<0.001
Paired	2.35 => 2.82 (+0.47); P<0.001	2.57 => 3.08 (+0.51); P<0.001	2.77 => 2.92 (+0.15); P<0.12	2.13 => 2.86 (+0.73); P<0.001

*session 1 content (N=107; # completed evaluations: knowledge 48-unpaired, 38 paired; questions 49 unpaired, 39 paired).

**session 2 content (N=93; # completed evaluations: ADL care 41-unpaired, 26 paired; resources 34 unpaired, 22 paired)

A138

Immersion Patient-Role Simulation Using Remote Patient Monitoring: Building Empathy and Clinical Insight in Geriatric Nurse Practitioner Training

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Background: Effective geriatric care demands deep understanding of daily multimorbidity, polypharmacy, and technology burdens. Didactic teaching rarely conveys these realities.

Methods: Thirteen Adult-Gerontology NP students (mean age 36.3 years, range 27-54; 11 female, 2 male) embodied a 72-year-old patient with CHF, diabetes, hypertension, osteoarthritis, anxiety, and insomnia for 10 days. Using cellular RPM devices, they transmitted daily basal vitals (weight, BP, glucose, SpO2) and followed an 8-drug regimen (simulated with candy). Pre/post perceptions used 5-point Likert scales and were analyzed with paired t-tests and Wilcoxon signed-rank tests. Open-ended reflections underwent thematic analysis.

Results: Quantitative (n=13): Feasibility improved (2.30 to 1.80; t-test p=0.03, Wilcoxon p=0.04). Liability decreased (3.20 to 2.30; p<0.01). Importance rose sharply (2.70 to 4.30; p<0.001). Perceived ease of medication adherence fell dramatically (4.30 to 2.50; p<0.01), showing students now recognize complex regimens as very difficult. Time consumption improved (t-test p=0.04); cost perception slightly increased (p<0.05). Qualitative themes: empathy for polypharmacy ("I constantly double-checked if I took my meds"), retirement does not mean unlimited time ("being retired does not mean having unlimited time"), technology barriers, and strong appreciation for RPM trend detection and hospitalization prevention.

Conclusions: This 10-day immersion creates transformative empathy, shifts RPM perceptions positively, and debunks the myth that medication adherence is easy.

Implications for AGS Attendees: Low-cost, scalable simulation aligns with Age-Friendly Health Systems and Choosing Wisely by promoting deprescribing and human-centered RPM ideal for fellowship, residency, and faculty development.

Future Directions: Add smart pill dispensers, intentional glitches, mid-simulation deprescribing, large-print guides, video tutorials, teach-back, interprofessional expansion, and longitudinal practice tracking.

A139

Project Management and Student Focus Groups: Rapid Refinement of an Interprofessional Geriatric Training Program

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Background: A Geriatric Workforce Enhancement Program (GWEP) created a 12-week, 20-hour/week hybrid interprofessional education (IPE) course using the Age-Friendly Health Systems 4Ms framework (What Matters, Medication, Mentation, Mobility) to build team-based geriatric competencies among practicing clinicians and direct-care workers serving underserved older adults.

Methods: An interprofessional faculty council collaborated with an instructional designer and a dedicated project-management

specialist who applied formal project-management tools (project charter, Gantt timeline, risk register, responsibility-assignment matrix) to ensure on-time design and delivery of the inaugural cohort (n=10). Immediately after course completion, an independent facilitator led a structured 3-hour focus group. The resulting 80 student-generated suggestions were systematically reviewed in a 4-hour faculty session; 62 were deemed feasible and assigned owners and deadlines for implementation.

Results: Priority revisions for the March 2026 cohort include weekly blinded interprofessional case-study team presentations, permanent small learning teams, expanded social-work and legal content, and required opening/closing in-person sessions. Qualitative feedback was strongly positive; pre-post attitudinal measures trended favorably.

Conclusions: Combining rigorous project-management discipline with deep, structured student focus-group engagement enabled rapid, transparent, evidence-based curriculum improvement within one academic year. This replicable approach demonstrates how geriatric workforce training programs can accelerate quality enhancement by systematically integrating learner voice and proven process methodology.

A140

Creation of a Geriatrics-Focused Curriculum for Ambulatory Care Coordination Teams

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Background: Interdisciplinary teams of nurses, social workers, and community health workers (CHWs), are essential in providing comprehensive outpatient care to older adults (OAs). They can address caregiver burnout, decrease rates of institutionalization, prevent hospitalizations, improve quality of life and decrease healthcare costs. However, primary care teams often manage geriatric syndromes and complex social needs without specialized training. We aimed to develop a curriculum for Ambulatory Care Coordination Teams (ACCTs) to address gaps in geriatrics practice.

Methods: Kern's six-step model for curriculum design served as the framework for our curriculum development: (i) problem identification and general needs assessment; (ii) targeted needs assessment- we surveyed participants on topics of interest and gaps in knowledge related to Geriatrics, (iii) goals and objectives- were developed collaboratively by a multidisciplinary team and centered around the care of OAs; (iv) educational strategies- didactic lectures and cases based on needs assessment were developed; (v) implementation- curriculum delivery at monthly ACCTs meetings, attended by staff from clinics associated with an academic center; (vi) evaluation and feedback- pre/post participant surveys of knowledge, self-efficacy, and practice behaviors will be collected.

Results: Of 34 ACCT members surveyed for needs assessment, 29 (85%) responded: 38% were registered nurses, 34% CHWs, and 28% had other roles. Experience ranged from 1-24 months, with 24% having less than 6 months in their current position. Selected topics included Transitions of Care (55%), Adult Protective Services (35%), Medication Safety (45%), and Mood disorders (52%). Respondents indicated interest in case-based learning (69%) and community resources/handouts (79%) that could be provided to patients and families. These preferences guided curriculum development.

Conclusion: Ambulatory interdisciplinary teams are instrumental in caring for OAs in primary care. Dedicated geriatrics education is essential to meet the complexities of this population's needs. This targeted curriculum aims to strengthen team capacity and improve outcomes for OAs.

A141

Gamifying the 4Ms: A QR-Driven Skills Tracker to Improve IM Resident Competency in Age-Friendly Care

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The Age-Friendly Health System (AFHS) 4Ms provide a structured approach to high-value care for older adults. A prior needs-assessment survey of Internal Medicine (IM) residents revealed deficits in AGS/ADGAP geriatrics competencies, particularly in Mobility-aligned domains. To promote competency development, accessibility of teaching tools, and engagement across rotations, we developed an interactive QR-based educational platform. Following baseline survey analysis in May 2024 (n=35), AGS/ADGAP competencies were mapped to 4Ms domains to identify targets for intervention. We created a QR-accessible digital hub containing concise reference guides, short teaching videos, slide decks, and other geriatrics learning tools. Features in development include a "Geriatrics Bingo Card" that residents can use to document exposures and log completed skills thus gamifying the progression toward 4Ms competency. The QR code is currently displayed on an inpatient unit for older adults (ACE unit) to integrate learning into clinical flow. A post-intervention survey will be administered at the same academic cycle point to assess changes in self-reported proficiency, engagement, and competency completion. Baseline data showed that 71% (25/35) of residents had no geriatrics-focused medical school exposure, while 77% (27/35) completed at least one geriatrics rotation during residency. Lowest-rated competencies on a 1-5 scale included identifying pressure injuries and planning fall-prevention strategies. These results guided the design of the QR-based platform and bingo card to increase repetition, visibility, and practice of the competencies, especially in Mobility and skin integrity skills. Identified gaps in 4Ms-aligned competencies highlight the need for structured, accessible tools to reinforce geriatrics education. A QR-based instructional hub with gamified competency tracking offers a scalable model for strengthening geriatrics training across rotations. Pending post-intervention analysis, this framework may support wider adoption in residency programs seeking to operationalize AFHS principles.

A142

Participation in a case-based forum impacts clinical practice and enhances educational culture

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Background: Geriatrics clinicians routinely encounter medically complex and challenging encounters; however, opportunities for collaborative, case-based learning can be limited in busy clinical environments. To address this, we developed the Interesting Case Conference (ICC), a forum where fellows and attending physicians present challenging cases and engage in group discussion regarding evaluation and management. This lunch conference is held weekly during interview season and then bi-monthly for the rest of the academic year. The objective of our survey was to evaluate participants' perceptions of the ICC after 3 years to guide future directions of the conference.

Methods: We conducted a survey of fellows (current and former) and faculty who have participated in the ICC. We received 9 responses from 11 participants. The anonymous survey included three Likert-scale questions assessing perceived influence on clinical practice, collaborative behaviors, and case identification for future conferences. Open-ended questions solicited narrative feedback regarding strengths and areas for improvement. We did not collect demographic data.

Results: Participants reported a positive educational impact from the ICC. 6 of 11 participants strongly agreed or agreed that attendance had impacted their clinical practice. 7 of 11 strongly agreed or agreed that attendance encouraged them to reach out to colleagues more

often. 8 of 11 save clinical cases for presentation at future conferences. Qualitative comments emphasized the ICC's collaborative, nonjudgmental environment; its role in broadening differential diagnoses; and its value in reducing professional isolation. Several participants highlighted that the conference enhanced their sense of community within the division.

Conclusions: Implementation of the ICC was associated with perceived improvements in clinical reasoning, collaborative behaviors, and professional support among geriatrics fellows and faculty. These findings suggest that discussion-based forums may play a role in enhancing educational culture in geriatrics. In the spring, we plan to incorporate ICC into our regular division meeting programming, providing more faculty with the chance to participate. In the fall, we will continue to hold ICC as part of our interview day; next steps could include evaluating its impact on geriatric fellowship applicants.

A143

Geriatric Medicine Fellows' Program Choice: A National Survey

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Background:

Geriatric medicine faces a persistent workforce shortage despite an aging population and growing demand for geriatricians. National fellowship match data show unfilled positions each year, highlighting the need to better understand how applicants choose programs. Prior studies explored factors influencing choice of geriatrics as a specialty, but little is known about the components shaping applicants' fellowship ranking decisions. We identified factors most important to applicants when selecting a fellowship program.

Methods:

We conducted a national, cross-sectional survey of 2025–2026 geriatrics fellows and incoming 2026–2027 fellows in accredited U.S. programs. We created a survey based on prior validated surveys of internal medicine and geriatric psychiatry applicants, along with open-ended questions. Surveys were distributed through program coordinators. Instruments include Likert-scale items (1–5 = “very important”) that assessed program reputation, mentorship quality, research and education opportunities, workload, geographic location, and proximity to family. Demographic data and program region were collected to assess sample diversity. Descriptive statistics summarized the relative importance and variability of each factor.

Results:

Preliminary data of 15 respondents (mean age 31, 93% female, 47% White, 33% Asian, 20% family medicine residency graduates) from all four US geographic regions revealed that among the program-intrinsic factors, participants rated department culture (mean 4.53), perceived happiness of fellows (4.4) and of faculty (4.33), and impression of program leadership (4.33) the highest. Of the program-extrinsic factors, participants rated geographic location (4.33) and local social/recreational opportunities (3.6) as most important. Data collection is still in progress.

Discussion:

This national study of geriatric medicine fellows' is the first to assess factors influencing fellowship program ranking. Respondents rated program-intrinsic factors more highly than extrinsic factors when selecting a fellowship. Fellows' perceptions of people within the program emerged as the most influential considerations. The primary anticipated limitations are a low survey response rate and the lack of direct respondent interviews. Findings may guide programs in optimizing recruitment strategies, mentoring structures, and curricular emphasis to attract and retain future geriatricians.

A144

Gravity is Working Against Me: Improving Falls Evaluation and Management in Older Adults in a Skilled Nursing Facility.

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Background: Falls are a major cause of morbidity and mortality among older adults, with more than 14 million U.S. adults aged ≥65 experiencing a fall each year. Multifactorial interventions addressing individualized risk factors such as medication burden, vision impairment, environmental hazards, and podiatry needs can reduce fall incidence in high-risk populations. Despite compelling evidence, gaps persist in consistent screening, risk stratification, and implementation of validated fall-prevention and harm reduction strategies, highlighting the need for high quality provider assessments.

Methods: A retrospective review of documented falls occurring between August 1–31, 2025 was conducted at a 500-bed skilled nursing facility in New York City. A process map and fishbone diagram were created to identify areas for intervention[SL1]. A standardized data abstraction tool was generated for structured review. Extracted elements included vitals, physical exam, orthostatic measurements, FRAX score and post fall evaluations. Extracted data was analyzed using a pareto chart. Deficits were identified in the areas of high-risk medication evaluation, osteoporosis evaluation and management. From this data a targeted education session was conducted for providers.

Conclusion: This baseline review provides the foundation for fall-prevention and harm reduction interventions at our institution, and the project is currently ongoing as we continue to expand data collection and implement evidence-based strategies. Our next steps will include analyzing the effectiveness of education and evaluating for further QI interventions.

A145

Collaboration Counts: Academic Partnerships Elevate Family Medicine Geriatrics Residency Education

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Background: The Medical College of Wisconsin (MCW) Department of Family & Community Medicine (DFCM) has 5 residency sites. In July 2023, a new North Side family medicine residency (NS-FMR) partnered with the Department of Medicine's (DOM) Division of Geriatric and Palliative Medicine to meet graduate medical education (GME) requirements for family medicine residency programs in geriatrics.

Methods: With support from a Health Resources and Services Administration (HRSA) Geriatrics Academic Career Award grant, a novel geriatrics rotation was created including: 1) a month-long inpatient geriatrics clinical rotation; and 2) an embedded, longitudinal, case-based, educational series modeled after Project ECHO (virtual learning framework). The inaugural NS-FMR PGY 2 residency class enrolled in the curriculum in July 2024. In July 2025, an additional site within the DFCM requested creation of a Geriatrics rotation for its residents. Assessment of the curricular impact on learners from the first year utilized the Miller Pyramid for clinical competence and Kirkpatrick's model for training program evaluation.

Results: To date, 64% (18/28) PGY2 NS-FCM residents have completed the rotation. All learners reported ample opportunity for patient care and rated the quality of teaching as high. With addition of the second FMR site, 38 FCM residents will complete the rotation this year (42% increase). Some learners attended multiple case-series and completed evaluations (N=34) with pre/post results showing improved learner comfort on age-friendly elements from 2.97 to 3.94 on a

5-point scale (1=low, 5 =high), with 82% of learners rating quality of teaching during the case sessions as somewhat or far above average. 94% (N=32) of learners anticipated changing their clinical practice after attending sessions and would recommend sessions to others.

Conclusion: Preliminary findings indicate that this cross-departmental geriatrics curriculum meets a critical training need and generates momentum for broader adoption across residency sites. Ongoing evaluation will determine the model's long-term effectiveness and its potential to serve as a scalable framework for expanding geriatrics education across diverse training environments. Sustainability will be an issue since GACA support is time limited. Further expansion to other DFCM residency sites is limited by available slots for resident learners.

A146

Igniting the 4Ms at the Frontline: An Age-Friendly Bootcamp Enhances Readiness Within 210 Minutes

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Background

Structured education on geriatric principles remains limited in many hospital settings. The "4Ms framework" (What Matters, Medication, Mentation, Mobility) offers an evidence-based model for person-centered, age-friendly care. While the framework improves patient outcomes, studies evaluating educational initiatives to operationalize the 4Ms in clinical practice are scarce. This project implemented a concise, interactive "Age-Friendly Bootcamp" for inpatient staff and assessed its immediate impact on knowledge, confidence, and readiness to incorporate 4Ms into daily care.

Methods

We conducted a single-site pre-post evaluation among interdisciplinary inpatient staff at an academic teaching hospital in New York. The 210-minute bootcamp, designed by an interdisciplinary team, led by nursing leaders, utilized didactic content and case-based discussions to operationalize each of the 4Ms. Anonymous surveys evaluated self-rated knowledge and confidence using five-point Likert scales (1=Low, 5=High). Pre- and post-intervention scores were compared using t-tests.

Results

Out of 35 participants, 30 completed the pre-survey, and 31 completed the post-survey. Statistically significant improvements were observed across all domains. Mean self-rated knowledge increased from 3.73 to 4.81 ($p<0.001$), and confidence increased from 3.91 to 4.81 ($p<0.001$). Ninety-four percent (29/31) of participants reported an intent to change their clinical practice based on the session. Qualitative feedback highlighted satisfaction with the case-based format and a desire for ongoing training.

Conclusion

A brief, structured 4Ms-based educational session was associated with significant immediate improvements in geriatric knowledge, confidence, and readiness to implement age-friendly practices. This intervention demonstrates that a focused 210-minute encounter can effectively enhance awareness of person-centered care. Future work will evaluate the long-term sustainability of these educational gains and their impact on patient outcomes.

A147

Geriatrics 5Ms Curriculum for Internal Medicine Residents: Integrating Large Language Models into Case-based Classroom and Clinical Rounds

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Background: Aging population is growing globally. Geriatrics education for internal medicine (IM) residents and other health professional trainees is used to prepare them to provide high quality care for growing older population. Geriatrics 5Ms (Mind, Mobility, Medication, Multi-complexity, and Matters most) are new minimum geriatric competencies for internal medicine (IM) residents in U.S. Geriatrics 5Ms-based curriculum for IM residents is needed but rarely developed. The application of large language models (LLMs) to medical education is growing rapidly, but not to geriatrics education. Therefore, we integrated LLMs into geriatrics 5Ms-based curriculum for IM residents.

Methods: We used "See One and Do One" format to develop this LLMs integrated Geriatrics 5Ms-based curriculum for IM residents who came to our 2-week geriatrics rotation since June of 2024. In the "See One" session, the instructor (author) introduced geriatrics 5Ms framework and demonstrated the application of LLMs to 8 geriatrics 5Ms-based vignettes with total 11 clinical questions. Each question was answered sequentially by IM residents, the instructor, and LLMs and discussed. In the "Do One" session, IM residents presented to the instructor one of their patients with a key clinical question during the clinical rounds. The answers by the instructor and LLMs were compared to IM residents' assessment and management plan for the same patient.

Results: Total of 47 IM residents participated in this curriculum. The formal evaluation started in July 2025. 100% (10/10), 100% (10/10) and 80% (8/10) IM residents were confident in applying geriatrics 5Ms and age-friendly care and LLMs to clinical practice respectively. 84 % (8.4/10) favored this curriculum (NPS promoter score was 84%, world class). LLMs had similar answers to 11 clinical questions by the instructor and IM residents and rarely produced hallucinations.

Conclusion: This LLMs integrated geriatric 5Ms-based curriculum was well perceived by IM residents and improved IM residents' confidence. It could potentially enhance geriatrics education for IM residents and other trainees. We are developing LLMs prompts to extract geriatrics 4Ms (geriatrics 5Ms without multi-complexity) documentation using EMR clinical notes as a surrogate marker to assess whether IM residents apply 4Ms to their clinical practice.

A148

ChatGPT Integrated Geriatrics 5Ms-based Curriculum for Senior Internal Medicine Residents: Competency Assessment

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Background

Teaching geriatrics to the internal medicine (IM) residents and other trainees is needed to meet the needs of growing aging demographics. Geriatrics 5Ms (Mind, Mobility, Medication, Multi-complexity, and Matters most) is a new minimum geriatrics competence for IM residents in US. A growing trend of utilizing ChatGPT enhances graduate medical education, but not to geriatrics education. Competency assessment for geriatrics 5Ms-based curriculum is rarely reported. Therefore, we developed a geriatrics 5Ms-based curriculum integrating with ChatGPT and competence assessment for senior IM residents.

Methods: This curriculum was composed of the following two sessions. In the first session, we developed a one-hour case-based geriatrics 5Ms didactic integrating with ChatGPT. It started with the conceptual frameworks of geriatric 5Ms, age-friendly health system

(AFHS), and interprofessional competence. A geriatric case was then unfolded accompanied by nine geriatric 5Ms-based clinical questions. Responses to each question by IM residents, the instructor, and ChatGPT were compared and discussed. Pre and posttests were performed. Net Promoter Score (NPS) was calculated to evaluate this curriculum. It was presented at 2025 AGS conference. For the second session, we developed 20 geriatrics 5Ms-based multiple choices (majority), true or false (minority), and open (minority) questions to senior IM residents as a geriatrics 5Ms competence assessment.

Results: For the first session of the curriculum, ChatGPT outperformed senior residents for 8/9 geriatrics 5Ms-based questions. For the second session of the curriculum, ChatGPT outperformed senior residents in 20 geriatrics 5Ms-based clinical questions. Majority of IM residents are ready to apply geriatric 5Ms and AFHS to their clinical practice. NPS scores for both recommending geriatric 5Ms and AFHS were favorable.

Conclusions: ChatGPT Integrated Geriatrics 5Ms-based Curriculum Integrating for Senior Internal Medicine Residents with competency assessment is a new way to teach geriatrics and to assess teaching for IM residents.

A149

Geriatric Fellowship with Cardiology Focus: A strategy for Fellowship Recruitment

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Background: Geriatric medicine fellowships have more available positions than applicants, resulting in seats left unfilled across the country every year. Recruitment to geriatric fellowship programs is challenged by limited exposure to geriatric medicine and lower financial compensation compared to other subspecialties. Our program has been seeking to encourage applicants who might benefit from geriatric training, especially those interested in pursuing further subspecialty education.

Method: In 2024, in addition to the standard fellowship track, with the collaboration from the cardiology division at the Veterans Affairs Medical Center, we created a geriatric-cardiology track (GCT) within the geriatric medicine fellowship program at Brown University. We recruited trainees interested in geriatric medicine and also planning to apply for a cardiology fellowship the following year. In addition to completing all required rotations in geriatric medicine per ACGME guidelines, GCT fellows are assigned a weekly half-day cardiology clinic at the VA and a 6-week rotation in geriatric cardiology. GTC fellows participate in cardiology fellowship didactics and conferences. Cardiology faculty provided mentorship on cardiology-related research projects.

Result: Alongside the core geriatric curriculum, GCT fellows received additional education, clinical exposure, and research in cardiology. Each GCT fellow completed research related to a cardiology topic and successfully presented their abstracts at the annual AGS meeting in 2025. From the 2024-2025 class, 2 out of the 3 GCT fellows matched into a cardiology fellowship program. Currently, in the 2025-2026 class, we have 2 GCT fellows. One has applied for the cardiology fellowship. The second fellow changed his intent, and plans to practice as a geriatrician.

Conclusion: The success of our geriatric cardiology track program within our geriatric medicine fellowship is due to collaboration with the division of cardiology and a well-structured curriculum. The GTC provided advanced training in the care of older adults and offered fellows significant opportunities to engage in cardiology-related scholarly research. Notably, the implementation of this targeted recruitment strategy has yielded promising outcomes for our program, supporting both educational and professional development among our trainees as well as future Geriatric Cardiologists.

A150

Rewriting Ageism: A Directed Summative Content Analysis of Student Language From a Narrative Education Intervention

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Background

Ageism is an increasingly recognized, widespread negative influence on older adult healthcare. Many curricula aim to address this; however, their outcomes are mainly trainee self-report, with little known about actual behavioral change. Most curricula occur after students start clinical rotations, likely underpreparing them to face ageism in the clinical environment, making early interventions critical.

Methods

First-year medical students completed a one-hour patient-narrative session. Students responded to “describe the experience of getting older” before and after the session. A qualitative directed summative content analysis, using the WHO definitions of ageism and anti-ageism as the framework, was performed. A pre/post 5-point Likert survey assessed session value and confidence in discussing ageism.

Results

125 students participated in the narrative intervention, with 89 and 53 students completing the pre- and post-surveys, respectively. Student responses displaying anti-ageist language increased to 49% (26 students) from the pre-intervention 30% (27 students). Sixty percent of students using anti-ageist language post-intervention had not done so pre-intervention. Ageist language remained similar pre (84%) and post (81%). About 25% of responses, pre and post, showed multiple types of ageism (stereotype, prejudice, discrimination, or systemic). Frequencies of types were largely stable except for fewer stereotypes (80% to 70%) and increased discrimination descriptions (0% to 13%). Students reported positive session value and greater confidence.

Conclusions

This study offers early, yet rare behavioral-level evidence in ageism education, going beyond the self-report outcomes that dominate. In this sample, self-report outcomes were positive, but the presence of ageist language persisted. Students without prior anti-ageist language drove the post-intervention increase. Although limited by sample size and response rate, findings show signals of shifting pre-clinical views on ageism and display how student perspectives map to WHO ageism definitions. Behavioral-language assessment offers a needed lens for strengthening ageism curricula with hopes of a future workforce delivering age-inclusive care.

A151

Teaching Medical Students' About Neuropsychiatric Symptoms of Dementia

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Background: Medical students usually rotate through geriatrics as an elective during their senior year. Their experience with neuropsychiatric symptoms of dementia is limited. The objective of this education model was to assess and improve medical student knowledge on neuropsychiatric symptoms of dementia.

Methods: During the Geriatrics rotation, students spend time in outpatient clinics, memory disorders clinic, geriatrics evaluation and management inpatient, home base primary care and nursing homes. In the memory disorders clinic emphasis is based on cognitive evaluation along with evaluation of neuropsychiatric symptoms of dementia. Students receive didactics, clinical experience with

patient contact, followed by presentation/treatment plan development. The didactics portion was enriched by interaction with an interdisciplinary team of providers including neuropsychologists, geriatricians, social workers, and geriatric psychiatrists. Knowledge of medical students was assessed at the beginning and at the end of the rotation. Pre- and post-assessments included questions on different types of neuropsychiatric symptoms of dementia, their etiology, and treatment.

Results: Results: 114 students participated. Very few students had sufficient knowledge regarding dementia and neuropsychiatric symptoms at pretest; prevalence of Alzheimer's dementia (12%), prevalence of neuropsychiatric symptom (25%), key consideration for prescribing antipsychotics (65%), neurotransmitter involved (37%) and medication used for treatment of agitation (35%). However, at pre-test students were more familiar with depression in AD (90%), consequence of apathy in AD (95%) and non-pharmacological interventions (98%). Students' knowledge improved significantly at post-test in the areas of prevalence of neuropsychiatric symptoms (68%, $p<0.001$), key consideration for prescribing antipsychotics in AD (88%, $p<0.001$), neurotransmitters involved (57%, $p=0.003$), and medication used for treatment of agitation (77%, $p<0.001$).

Conclusion: Training senior medical students on neuropsychiatric symptoms of dementia will help improve their knowledge about the diagnosis and management of such symptoms.

A152 Encore Presentation

Ready for the Aging Population? A Needs Assessment of Geriatric Education Among Graduating University of Wisconsin – Madison Physician Assistant Students

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Background

Physician Assistants/Associates (PAs) play a growing, critical role in caring for older adults necessitating strong curriculum in geriatrics for PAs. However, PA educational standards are vague, leading to highly variable curricula that is difficult to study. Additionally, little is known about how PA curricula align with the AGS competencies for graduating medical students.

Methods

We performed a student perspective needs assessment of graduating PA students at UW-Madison via survey to assess opinions on the geriatrics curriculum, including confidence in key geriatric knowledge and skills. A series of five-point Likert scale questions were created based on the AGS competencies for graduating medical students. Additionally, students selected individual content topics for which they wanted more education. Responses were analyzed using descriptive statistics.

Results

All sixty graduating students completed the survey. 73% rated the curriculum positively (mean 3.87/5). *Relevance to future career* had the highest mean (4.27). Confidence in specific geriatric skills varied. Four out of eight skills (*primary care, hospital care, mobility evaluations, and eliciting patient priorities*) had majority positive responses with means between 3.83 and 4.1. Students felt least confident in *applying 4 M's Framework* (mean 2.52). Though *geriatric pharmacology and dementia care* had means between 3-3.5, they were also most frequently selected for desiring additional education (78% and 67% respectively).

Conclusions

Overall opinion on the curriculum was positive. Though an upstream signal, student opinion of relevance to future career was high. Content areas of *primary care, hospital care, mobility evaluations, and eliciting priorities* were clear strengths. *4M's framework* was unsurprisingly low, as it is not currently taught but is increasingly

important to include in geriatrics curricula. *Dementia care* and *geriatric pharmacology* are clear targets for re-design and innovation as current curriculum devotes significant time in these areas. Finally, this is one of the first needs assessments for geriatric PA curriculum in twenty years, and the first to assess alignment to current AGS competencies.

A153

Fellow-Led QI Education on Falls and Polypharmacy Across Care Settings

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Background:

Falls and polypharmacy are major, preventable causes of morbidity in older adults. Providers across inpatient, outpatient, and long-term care (LTC) settings often lack structured, evidence-based training to identify and reduce these risks. To address this gap, geriatrics fellows implemented an interprofessional quality improvement curriculum focused on fall prevention and safe, patient-centered medication management.

Methods:

Fellows delivered educational sessions to faculty, fellows, residents, nurses, advanced practice providers, medical students, and staff across inpatient, outpatient, and LTC settings. Content emphasized identifying high-risk populations, using validated fall risk screening and prevention strategies, recognizing polypharmacy risks, and applying deprescribing frameworks using the Beers and STOPP/START criteria. Participants completed pre- and post-education surveys (5-point Likert scale) assessing knowledge, confidence, and fall and medication management skills. Descriptive statistics summarized changes in mean scores and percent improvement.

Results:

Forty-four learners completed both surveys (faculty $n=4$, fellows $n=3$, residents $n=4$, nurses $n=5$, medical students $n=19$, others $n=9$). Post-education scores improved across all domains: understanding fall risk populations rose from 3.97 to 4.36, confidence in assessment from 3.72 to 4.05, fall prevention skills from 3.56 to 4.39, awareness of polypharmacy risk from 3.89 to 4.43, confidence in identifying inappropriate medications from 3.36 to 4.27, deprescribing strategies from 3.39 to 4.18, and overall medication management skills from 3.25 to 4.39. The composite mean increased from 3.58 to 4.26 (19 percent). All improvements were statistically significant ($p < 0.001$) with a moderate to large effect size (Cohen's d approximately 0.8).

Conclusion:

This fellow-led, interprofessional initiative significantly improved learners' knowledge and confidence in managing falls and polypharmacy in older adults. The largest gains were in deprescribing confidence (27 percent) and fall prevention skills (23 percent). Embedding fellows as educators within a structured QI curriculum strengthened interdisciplinary competence, increased awareness of safer prescribing, and supported more effective fall reduction practices across care settings.

A154 Encore Presentation

"The Value and the Need": Preparing BSN Students for Long-Term Care Employment

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Long-term care (LTC) settings consistently struggle to meet staffing demands, especially adequate registered nurse (RN) coverage. With an increasing US older adult population, the need for LTC is

expected to grow. The Center for Medicare and Medicaid made staffing recommendations to increase RNs employed in LTC. BSN nursing education focuses on general nursing knowledge heavily centered on acute care settings, not specific training in LTC. With support from the (grant/team name) grant, the team developed an innovative course with tuition support for five students selected from a competitive pool of thirteen applicants. The course provided skills and knowledge focused on LTC settings, care of older adults, and 24 hours of clinical experience in LTC. Qualitative inquiry throughout the course included pre/post course discussion and reflection on the experience. Analysis indicated that the students developed an improved attitude to LTC work, including increased appreciation for the RN role in LTC. The students found the course to be comprehensive, yet reasonable to accomplish with other educational demands of their BSN program. All five students indicated intention to seek LTC employment, if not upon graduation, at some point in their career. One student said that she could “really see the value and need” for BSN RNs in residential care. To meet the demand for BSN RNs in LTC, such programming is essential in BSN programs (eventually nationwide). The course will be repeated with ongoing data collection and tracking of employment sites upon participant graduation.

A155

Passport to Geriatrics: Supporting competency-based learning

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Background: Geriatric medical education is essential yet often fragmented, particularly when rotations span multiple care settings. This can create variability in clinical exposures and difficulty ensuring consistent learning. To support more proactive, self-directed learning, a tool was developed to help students self-identify gaps, seek out targeted experiences, and ensure they are progressing toward mastery of core geriatric medicine competencies.

Methods: A “Passport to Geriatrics” was created from the AGS/ADGAP Minimum Competencies in Geriatrics for Medical Students and implemented with third- and fourth-year medical students (n=8) during a 3-week clinical immersion within a 4-week elective. The tool included an overview of 13 core geriatric topics and a checklist of 27 clinical skills aligned to each competency, which students were encouraged to complete during clinical encounters. An anonymous, retrospective pre/post self-assessment (1=Novice to 5=Expert) self-assessed competency in all 27 domains. Analyses were conducted using the Wilcoxon signed-rank test with Benjamini-Hochberg correction. The study was IRB-exempt.

Results: All eight students completed at least one skill during the rotation. Across all 27 domains, post-rotation median competency scores were higher than pre-rotation values, with 25 domains showing statistically significant improvement (p<0.05). Skill-exposure data showed wide variability, with completion rates ranging from 0% to 100%. Higher-frequency skills included recognizing atypical presentations (100%) and developing fall-mitigation plans (87.5%), while lower-frequency skills included use of a nonverbal pain scale (0%) and calculating creatinine clearance for age-appropriate dosing (12.5%). Learners reported the passport helped them identify knowledge gaps and use quick-reference materials to guide a more intentional approach to the rotation.

Conclusions: Integrating the “Passport to Geriatrics” into a geriatric medicine elective was associated with meaningful gains in self-rated competencies and provided educators with a mechanism to track student exposure across care settings ranging from outpatient clinics to a geriatric inpatient service. By capturing experiences across settings, the tool helps identify inequities in exposure and inform curricular improvements. Although gains may reflect additional course elements, early evaluation suggests the passport is feasible and valued by learners.

A156

Mobile Immersion Tour in Nursing Homes Curriculum

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Background

The growing aging population and rising demand for dementia and long-term care intensify the US healthcare workforce shortage. Despite this, many health professions programs provide limited training in geriatrics, dementia care, and nursing home environments, leaving graduates underprepared to care for older adults in long-term care settings. As part of a Geriatric Workforce Enhancement Program, faculty at the University of North Texas Health Science Center partnered with a nursing home and the Area Agency on Aging (AAA) to develop a Mobile Immersion Tour Training in Nursing Homes curriculum designed to enhance learners’ understanding of dementia care and age-friendly long-term care.

Methods

Using Texas Health and Human Services educational materials, faculty created a curriculum integrating social determinants of health, resident rights and elder justice, long-term care operations, and the aging services continuum. The Age-Friendly Health Systems 4Ms framework guided content emphasizing person-centered nursing home care. As part of this curriculum, first-year health professions students completed a guided tour led by a AAA ombudsman in June 2024 (n=10) and June 2025 (n=9). QR-coded mobile stations throughout the facility prompted observations related to 4Ms, dementia care, resident safety, rights, quality of life, interdisciplinary team roles, and staff-patient interactions. Post-tour surveys assessed perceived usefulness, confidence in addressing dementia caregiver questions, and understanding of challenges faced by adults living with dementia.

Results

Participants (n=19; 58% female; 47% White, 47% Asian; 84% non-Hispanic) reported high satisfaction, with the majority agreeing or strongly agreeing with all evaluation questions about the tour experience. Qualitative analysis themes included increased empathy, recognition of dementia-friendly design principles, and a desire to engage in advocacy and aging-focused professional roles.

Discussion

The Mobile Immersion Tour effectively strengthened learners’ awareness of person-centered dementia and nursing home care and fostered motivation to apply this knowledge in future practice. This inter-organizational collaborative model offers a replicable, sustainable approach to expanding geriatrics education and supporting workforce development in aging services.

A157

Mind the Gap: Mapping Geriatrics Education in an Evolving Medical School Curriculum

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Background

By 2060, the U.S. population aged 65 and older will exceed 88 million, more than double 2022 levels, underscoring the need for a healthcare workforce prepared to meet their complex needs. Nearly all medical students will care for older adults making a robust undergraduate medical curriculum grounded in geriatric principles essential. This project aims to evaluate the current state of geriatric training within the University of Colorado School of Medicine curriculum.

Methods

Using the Geriatric 5Ms framework and the American Geriatrics Society’s “Minimum Competencies in Geriatrics for Medical Students,” geriatrics faculty identified priority topics for integration across all four years of medical education. The existing curriculum map was reviewed to assign each topic to an ideal year of instruction

based on the curricular structure of the School of Medicine. For MS1 year, a structured search identified where geriatric concepts were included and where gaps existed.

Results

Keyword searches within the first-year curriculum identified variable incorporation of geriatrics concepts. "Geriatric" appeared in 2 session descriptions, and "older adult" appeared in 1 session within the Reproductive System and Life Cycle block. Terms such as "death," "dying," "matters most," and "mobility" yielded 1–2 sessions, primarily within the same block. "Dementia" was identified in 2 sessions within the Nervous System and Mind and Behavior curriculums. "Advanced care planning" appeared in 4 sessions across the Nervous System and Endocrine blocks. No sessions were identified using the terms "5Ms," "frailty," or "multicomplexity." Of the 46 sessions deemed relevant or potentially relevant to geriatrics based on the list of priority geriatrics topics, only 13 (28%) explicitly referenced geriatrics-related terms in their descriptions.

Discussion

Medical students require a strong foundation in geriatrics to care for older adults across specialties. This project highlights gaps in geriatrics content and provides a structured approach for integrating essential geriatric concepts throughout undergraduate medical education. The methodology developed may serve as a model for other institutions seeking to enhance geriatrics training for medical students.

A158

From Polypharmacy to Precision: Evaluating Deprescribing Impact in Geriatric Care

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Introduction:

Polypharmacy is highly prevalent in older adults and is associated with falls, cognitive impairment, and increased hospitalization risk. Deprescribing, or the systematic discontinuation of unnecessary or harmful medications, is essential to improving medication safety in geriatric care. This study evaluates the impact of a structured deprescribing initiative using real-world patient data.

Methods:

Data from geriatric patients aged 70–85 years were extracted. Baseline prescriptions, post-intervention prescriptions, number of medications deprescribed, and dose reductions were analyzed. Absolute and percentage changes in medication count were calculated.

Results:

A total of 40 older adults were included in the analysis, of whom 15 (37.5%) underwent a documented deprescribing intervention. Among these 15 patients, the mean baseline medication count was 10.7, reflecting a high degree of polypharmacy in this population. Following the deprescribing review, the mean medication count decreased to 9 medications, demonstrating a trend toward regimen simplification with individualized adjustments.

Overall, 66% (10 of 15) of patients who received deprescribing interventions had at least one medication discontinued or dose-reduced. The most commonly targeted medications included benzodiazepines and non-indicated antiplatelet therapy, both considered high-risk in the geriatric population.

Discussion:

Although the net medication count remained stable, the intervention improved prescribing quality by removing potentially inappropriate medications (PIMs). Deprescribed agents such as alprazolam and aspirin without indication are supported by Beers Criteria as high-risk for falls, delirium, and bleeding in older adults. These clinically meaningful changes reflect the primary goal of deprescribing in geriatrics: risk reduction rather than numeric reduction of medications.

Conclusion:

Data analysis demonstrates that structured deprescribing is feasible and beneficial in the geriatric population. Even modest quantitative changes resulted in significant qualitative improvements in medication safety, supporting deprescribing as a core component of geriatric care

A159

A novel fellowship track to meet the needs of an aging population with cognitive impairment

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Background:

The FDA approval of monoclonal antibodies for Alzheimer's disease has fundamentally changed the landscape of dementia medicine, and dramatically increased the need for clinicians with specialized training. These clinicians must establish accurate diagnoses by integrating the clinical picture with biomarkers, genetic testing results, and imaging early in the disease course, closely monitor patients for adverse effects during and after treatment, and assess its benefit. The rapidly increasing number of patients requiring this complex medical management warrants more training of specialized physicians.

Methods:

At Mount Sinai Hospital, we developed a novel 2-year fellowship track that integrates Geriatrics and Behavioral Neurology & Neuropsychiatry (BNNP) to improve care for patients with dementia. This curriculum combines clinical training in both geriatrics (inpatient and outpatient geriatrics, long-term care, home visits, palliative care) and BNNP (cognitive health clinic, neuropathology, movement disorders, geriatric psychiatry, cognitive rehabilitation, neuropsychology) with collaborative research.

Results:

Education: The first geriatrics fellow with BNNP subspecialty training will graduate in 06/2026 with a skillset specifically tailored to older patients with dementia.

Clinical care: A geriatric attending and the cognitive geriatrics fellow staff a weekly BNNP clinic, focusing on the initial workup and medical management of older patients with dementia. In the geriatric clinic, fellows offer dedicated "cognitive health visits" to identify patients who need specialized BNNP management and can be prioritized for treatment.

Research: Within a collaboration between the departments, we established blood-based biomarkers for Alzheimer's disease in our geriatric primary care clinic, making them accessible for a larger population and allowing for more precise diagnoses.

Conclusion:

Expanded specialized training is needed to meet current and future patient needs. A dual fellowship combining geriatrics and BNNP subspecialty training is a way to train future "cognitive geriatricians", strengthen collaborative care for older patients with dementia, and synergize dementia research.

A160

DEMENTIACARE Workshops for Trainees in Primary Care

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Background: Primary care providers, when surveyed, have noted that they feel inadequately prepared in caring for people living with dementia. They are uncomfortable diagnosing dementia and answering questions from patients and caregivers about a dementia diagnosis. The DEMENTIACARE workshops were designed to address these

comfort issues and knowledge gaps. Workshop One, The Aging Brain, reviews normal cognitive aging and modifiable risk factors for dementia. Workshop Two, Diagnosing Dementia, reviews a differential diagnosis for dementia, cognitive testing, a primary care approach to labs and testing, and discussion of delivering a diagnosis of dementia to patients and caregivers. Both workshops include cases where learners practice skills taught during the sessions.

Methods: A geriatrician led Workshops One and Two during eight in-person sessions from January to April 2025. Both workshops were delivered in one session to groups of internal medicine and family medicine interns, fourth year medical students, and nurse practitioner students. Learners were evaluated through pre- and post-tests that were a combination of knowledge questions and subjective questions eliciting comfort with skills addressed during the workshops.

Results: Forty-eight learners completed the pre- and post-tests. Seven questions assessed knowledge and eight assessed comfort with skills. Learners had improved scores on six of seven knowledge questions in the post-test compared to pre-test answers. Improvement on comfort questions were also notable: only 31.3% of learners expressed that they were “very” or “somewhat comfortable” talking to patients and caregivers about cognitive changes on the pretest, whereas 95.9% were “very” or “somewhat” comfortable after the workshops. The proportion of learners that felt “very” or “somewhat comfortable” delivering a diagnosis of dementia increased as well (33.1% vs. 85.5%). Learners also had improved comfort performing and interpreting scores of cognitive tests.

Conclusions: Learners showed improved knowledge and comfort scores regarding normal cognitive aging, diagnosing dementia, and discussing cognitive changes with patients and caregivers after completion of the two workshops. These workshops will now be given yearly to internal medicine interns as part of their outpatient geriatrics block. Next steps include developing virtual workshops to disseminate to primary care providers regionally.

A161

Building an Age-Friendly Workforce: Geriatric 4M's Bootcamp

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Background: Medical education has utilized bootcamps as a vessel for providing education to trainees for decades, particularly at times of transition. Incoming trainees enter geriatrics fellowships with widely variable prior exposure to core geriatric principles. Our goal was to rapidly equip new trainees with a foundation of essential skills to deliver age-friendly care from the beginning of their fellowship year. We designed and piloted a Geriatric 4Ms Bootcamp and evaluated its impact.

Methods: The bootcamp consisted of four weekly 3-hour sessions delivered during regularly scheduled didactic time. Sessions were led by interprofessional faculty and targeted advanced learners across clinical disciplines with high-yield introductory content. Each session combined lectures, demonstrations, and small-group simulations, focusing on one of the Geriatric 4Ms:

[Table 1]

Attendance was tracked, and participants were surveyed after the series.

Results: A total of 8 learners joined one or more of the sessions; disciplines represented included geriatric medicine, geriatric psychiatry, social work, cognitive neurology, and nurse practitioner trainees. Most attendees (83%) were fellow physicians. Among survey respondents, 67% strongly agreed the bootcamp improved their confidence in managing older adults. Comments highlighted improved confidence in assessing needs for older adults and their caregivers; greater awareness of ageism among learners; and adoption of the 4M's framework.

Discussion: This bootcamp served as the foundation to our year-long geriatrics didactic curriculum. Subsequent didactic sessions

throughout the year will progressively build upon these 4Ms geriatric principles. Participant feedback confirmed the value of this early intervention. We will need to evaluate topic selection and ensure high-yield, and high-need content is prioritized. Future plans include expanding the series to include all 5Ms. This structured bootcamp model provides an efficient, replicable framework for rapidly preparing clinicians from different disciplines to deliver age-friendly geriatric care.

Table 1

Mind	Delirium Workshop
Mood	Geriatric Psychiatry Assessment & Late Life Anxiety
Mobility	Mobility and Falls & Intro to PT/OT
Matters Most	Serious Illness Conversations & Ageism

A162

Training Geriatric Fellows in High-Technology Assistive Tools for Use in Older Adults With Visual Loss

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Approximately 25% of older adults experience significant visual loss that affects daily functioning and independence. New assistive technologies can improve these limitations, yet many clinicians lack structured training on how to apply them in practice. This training introduces geriatric fellows to three key technologies used by visually impaired Veterans: (1) The VA iPhone program; (2) Meta glasses, a wearable device offering real-time environmental interpretation; and (3) ORCAM, an AI-assisted portable visual aid. Teaching methods include device demonstrations, hands-on practice, clinical scenarios, and observation of real patient interactions. Outcomes measured include trainee knowledge and their ability to match technologies to functional goals and rehabilitation needs.

Methodology:

The initiative takes place at the West Palm Beach VA Medical Center (WPB-VAMC) and its Blind Rehabilitation Center (BRC), a residential program with an average stay of 25 days. The BRC offers training in living skills, manual skills, orientation and mobility, visual skills, and recreation therapy. It serves approximately 65 new Veterans annually, each receiving 45-minute sessions focused on navigation, accessibility features, and functional use of smartphone-based visual assistance. Geriatric Medicine fellows rotating through the service participate in this curriculum.

Results:

Fellows observe clear improvements in Veterans' ability to use high-technology visual-assistive devices and gain practical knowledge regarding device function and clinical application. Over seven years, the BRC has served more than 600 Veterans, demonstrating measurable gains in Functional Independence Measure (FIM) scores. Devices such as the iPhone, ORCAM, and Meta glasses support tasks including money identification, barcode reading, color differentiation, and reading menus, mail, newspapers, and religious texts. Fellows recognize these tools' impact on autonomy, communication, and daily functioning, and Veterans consistently report high satisfaction.

Conclusion:

This project develops and evaluates a curriculum that trains geriatric fellows and medical residents to assess and integrate high-technology visual-assistive interventions for Veterans with visual loss at the West Palm Beach VA Medical Center.

A163

Development and Pilot of an Interprofessional Age-Friendly Leadership Academy

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Background: The United States healthcare system needs more interprofessional healthcare teams skilled in geriatric care to meet the needs of our growing older adult population. To achieve this, it is essential for health professions students to be trained in age-friendly care. Through a reciprocal university partnership, we developed and piloted a multimodal, longitudinal student training program called the Interprofessional Age-Friendly Leadership Academy (IPAFLA).

Methods: We utilized Kern's 6-step curriculum development framework to design and implement an 8-week pilot program for health professions students. Learning objectives focused on age-friendly competencies including the 4Ms framework, delirium management, communication skills, and interprofessional collaboration. Students were primed with four 2-hour onboarding workshops, followed by a 7-week internship that integrated didactics, clinical shadowing, Hospital Elder Life Program volunteering, asynchronous study, and group reflection sessions. Retrospective pre-post evaluations were completed for both the onboarding workshops and internship.

Results: Four students (3 occupational therapy, 1 pharmacy) successfully completed the pilot program. Onboarding workshop surveys showed an increase in self-rated knowledge of each topic discussed. Program conclusion survey data demonstrated a trend toward improvement in all measured competencies (7-Point Likert): communicating with older adults (median: 5→7), describing delirium (4.5→7), identifying nonpharmacologic delirium management (4→6.5), identifying the 4Ms (4.5→6), recognizing interprofessional roles (4→6.5), and overall geriatric care knowledge (4→7). Small sample size (n=4) limited statistical analysis. Qualitative data reflected appreciation of IPAFLA experiences.

Conclusions: Targeting health professions students with a multimodal, longitudinal training program in age-friendly care is feasible and may effectively improve self-rated geriatrics competencies. Through continuous quality improvement, this program will be refined and expanded to reach more health professions students in subsequent cycles.

A164

Integrating Telehealth into Fellowship Training: A Remote Model for Palliative Care in Nursing Homes

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Background: Workforce shortages in geriatrics and palliative care (PC), especially in rural states, limit access to high-quality nursing home (NH) care for residents with serious illness. Telehealth and interdisciplinary training offer scalable solutions. This abstract describes an educational model training a geriatric fellow to serve as the interventionist for the Improving Palliative Care Access through Technology (ImPacTT) telehealth PC intervention as part of her scholarly project.

Methods: In partnership with a clinical Geriatrics Fellowship, a current fellow - board-certified in hospice and palliative medicine - was trained as the ImPacTT interventionist. The intervention included proactive specialty PC telehealth consultations with residents and families focused on symptom management, advance care planning, and family engagement, as well as virtual huddles with the interdisciplinary NH care team. The fellow received targeted instruction in ImPacTT protocol implementation, as well as NH-specific geriatric

PC competencies, interdisciplinary collaboration, and telehealth skills under the mentorship from the project's UCSF geriatric PC physician expert. Training modalities included didactics, case-based discussions, debriefs of independent consults, and feedback sessions. All training and study activities were completed during scheduled scholarly time per ACGME requirements.

Results: The Fellow was successfully trained to administer the ImPacTT intervention to PC-eligible NH residents, combining the training of serious illness communications in PC with the expertise of geriatric care delivered in NHs. A geriatric-PC telehealth interventionist script was co-developed by the fellow; the team is in the process of developing a training toolkit for future interventionists.

Conclusions: Palliative and geriatric care naturally intersect in NHs. Training a geriatric fellow to serve as a telehealth PC interventionist is feasible, enhances workforce capacity, and prepares future geriatricians to lead innovative care delivery. This educational model integrates clinical, communication, and technology skills, and scaling it could help address critical workforce gaps in geriatrics and PC.

A165

Student Dental Care Confidence Boosted by Training in a Long-Term Care Dental Clinic

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Background:

Training students of oral health care (OHC) in a Long-Term Care (LTC) facility and community settings is an initiative to support 4- to 8-hour rotations of dental students, dental hygiene students, and dental assistant students in a dental clinic housed on the campus of a LTC facility.

Methods:

Eighty-two students had rotations in the Lucy Corr Foundation Dental Clinic between July 2024 and June 2025. The students' clinical confidence was assessed using a 35-item questionnaire to measure their level of certainty in clinical confidence when treating geriatric patients with medical, physical, and intellectual/cognitive disabilities as well as economic challenges and diverse cultural backgrounds by the end of their rotations. Their ageism misinformation was assessed using a 5-item questionnaire by the end of their rotations.

Results:

All average mean scores on the students' level of certainty in clinical confidence were between 4.31 and 4.86, indicating that they were somewhat or highly certain about their ability to treat geriatric patients with oral health issues after their rotations. All average mean scores on the students' ageism misinformation were between 1.65 and 3.03, indicating that they disagreed or strongly disagreed with the misinformation or were "neutral." Data shows that the students' profession discipline, student type (undergraduate & graduate), and race had a significant effect on their level of certainty in clinical confidence in terms of their assessment, diagnosing, planning, and documentation, but didn't have a significant effect on implementation. Furthermore, dental students had a significant effect on their level of certainty in clinical confidence with higher mean than other students; and Black students had a lower mean than students with other racial backgrounds.

Conclusions:

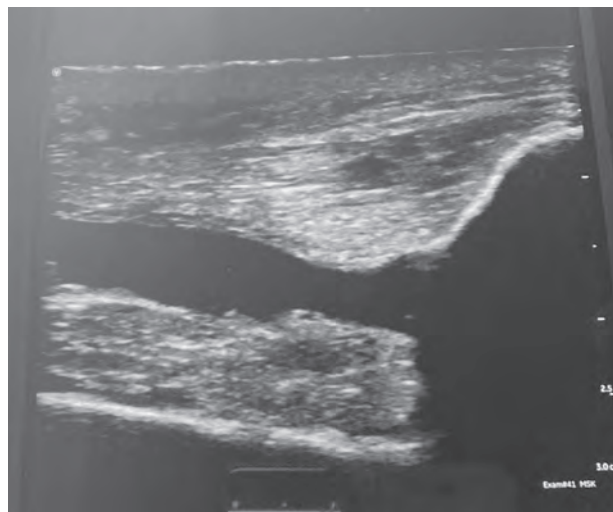
Oral health training offered in a dental clinic housed in a LTC facility supports the development of clinical confidence in students of OHC enabling them to confidently meet the oral and overall health-care needs of complex geriatric patients. However, subgroup analysis revealed disparate findings among students, highlighting opportunities to create a more inclusive learning environment. Although not all findings are statistically significant, they are practically significant and provide opportunities to improve experience and relevance for learners.

A166

Design and Evaluation of a Point-Of-Care Ultrasound (POCUS) Curriculum in Novice Users in Skilled Nursing Facilities (SNFs)

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POCUS has been studied extensively in ED, ICU, inpatient wards, and outpatient clinic settings. The role for POCUS is less well-defined in a SNF/long-term care (LTC) setting. Arguably, however, this is a higher need environment given the presence of older multi-morbid adults and limited diagnostic capabilities. The use of POCUS in the SNF/LTC setting may spare burdensome transfer to higher level of care, expedite diagnostic tests, and uncover unexpected diagnosis that change care goals. Our study question is "Can a POCUS curriculum help providers navigate diagnostic barriers in a novel LTC/SNF setting? If so, what is the amount of training required?" In spring 2024, we began a pilot flipped-classroom, spaced curriculum with 5 novice geriatrics faculty at 2 urban SNFs in Portland, Oregon. The curriculum included self-directed online modules and monthly hands-on sessions with a POCUS expert. To date, 19 scans have been logged with 10 clinical scans done with real-time supervision with the intention of answering a clinical question. Lungs was the most commonly scanned organ system, followed by skin and soft tissue and volume status. 3 scans confirmed a suspected diagnosis, 3 scans ruled out a diagnosis, 2 scans changed the urgency of a confirmatory test, 3 scans had unexpected diagnosis, and 0 averted escalation of care. The average amount of time taken to complete a scan was 7 minutes. As we are continuing to collect more data, our results thus far have shown promising clinical utility and feasibility of POCUS use by novice geriatrician learners.



A167 Encore Presentation

Qualitative Review - Training of Medical, Nursing, and Health Professions Students for the Care of LGBTQI+ Older Adults

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Background - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and all other identities (LGBTQI+) older adults remain an underrecognized group in healthcare and often receive care from clinicians with limited knowledge of their needs. Despite growing awareness of disparities, formal education on LGBTQI+ aging is rarely integrated into medical, nursing, or allied health curricula. This review examined existing educational interventions, their content and teaching methods, and their reported impact on learners.

Methods - A qualitative literature review was conducted using PRISMA methodology. The protocol was registered on the Open

Science Framework. Searches were performed across CINAHL, ERIC, Web of Science, Scopus, PsycINFO, Embase, and Medline. Two reviewers independently screened all articles, with disagreements resolved by a third reviewer. We collected data regarding learner type, intervention content, instructional modality, and outcome measures, when such information was available.

Results - Our review identified 1,657 articles, of which 13 met inclusion criteria. Articles were published between 2014 and 2023, all from North America (11 from the United States and 2 from Canada). Interventions were brief and feasible to implement across different settings and levels of training. Most studies addressed foundational content, with 38% focusing on terminology and health disparities. Educational methods included lectures, case-based learning, group discussions, films, theatre-based and virtual reality simulations. Across studies, 62% demonstrated immediate knowledge improvement, while only one study assessed and showed partial retention of knowledge at three months. Learner satisfaction, when evaluated, was consistently high.

Conclusions - Short training interventions on LGBTQI+ aging are feasible and effective in improving clinicians' knowledge and comfort across professions and levels of training. Despite these demonstrated benefits, such programs remain limited in number and vary widely in structure. Strengthening future curricula will require developing structured and longitudinal training models, integrating LGBTQI+ content into clinical education across disciplines, and implementing ongoing evaluation of learner skills, confidence, and satisfaction, as well as the impact on patient experience and health outcomes.

A168

The Required Home Safety Assessment: A Novel Teaching Opportunity

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Background

Assessing home safety is a required component of both the Centers for Medicare & Medicaid Services' Guiding an Improved Dementia Experience (GUIDE) model and the Annual Wellness Visit. Medical education does not typically include training on assessing home safety and prescribing durable medical equipment (DME) for community-dwelling older adults. This educational intervention sought to improve trainees' knowledge and confidence in this area.

Methods

We conducted a quasi-experimental pre-post study evaluating the effectiveness of a home safety assessment module for medical trainees. Participants included residents and medical students on their required Geriatrics rotation. A pre-test was administered prior to the intervention. Trainees then completed a 35-minute module (recorded audiovisual presentation) on conducting a home safety assessment and prescribing DME. Next, they completed an in-person home safety assessment with a trained GUIDE care navigator, utilizing a GUIDE home safety checklist. A post-test was administered to all trainees after the visit was completed.

Results

Eleven trainees participated in the program, including 9 (82%) internal medicine residents, and 2 (18%) medical students, all of which reported having no formal training in conducting home safety assessments. On both the pre- and post-test, all 11 (100%) trainees responded correctly when asked for the most common cause of injury for older adults living at home, while 1 (9%) trainee correctly answered both DME insurance coverage questions on the pre-test. On the post-test, 8 (73%) trainees correctly answered both DME insurance

coverage questions. All trainees indicated that completing the module and conducting a home safety visit would change how they care for older adults in the future. Additionally, 9 (82%) trainees “strongly” or “somewhat agreed” that, after completing the training, they felt confident identifying environmental hazards during a home visit that could contribute to falls, burns, or wandering risks in people living with dementia.

Conclusion

A robust home safety training program can improve health-care providers’ knowledge, attitudes, and skills around caring for older adults. We plan to extend this program to additional sites and disciplines.

A169

Teaching How to Teach: Empowering Geriatrics Fellows as Educators

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Background: Teaching is a core competency for fellowship-trained geriatricians, yet fellows’ confidence and opportunities to receive structured feedback remain limited. Building on prior experience at Mount Sinai Morningside, we aimed to standardize fellows’ teaching opportunities and feedback processes on the inpatient geriatrics service.

Methods: Beginning in August 2023, geriatrics faculty received faculty development on a standardized feedback tool adapted from the Stanford Faculty Development Program’s clinical teaching framework. Fellows were reminded of their teaching role before each rotation and led a teaching session for internal medicine residents. Faculty directly observed and provided structured feedback. Pre- and post-rotation surveys assessed fellows’ confidence and self-efficacy in teaching skills. Residents also completed pre- and post-session surveys evaluating confidence in learning geriatric concepts. Analysis used Wilcoxon signed-rank tests.

Results: 17 fellows rotated between August 2023 and May 2025; all provided teaching sessions, and 16 received structured feedback. 8 fellows planned academic careers; 7 were undecided; and 2 did not. 12 had prior teaching opportunities more than once a month, while only 11 had previously received feedback. Following implementation, fellows demonstrated significant improvements in confidence about medical teaching skills ($p < 0.0001$) and about teaching basic geriatric topics ($p < 0.0001$). Self-efficacy in specific teaching domains also increased, with gains in creating an effective learning climate ($p < 0.0001$), controlling the session ($p = 0.0001$), presenting in an organized way ($p = 0.001$), setting goals of sessions ($p = 0.0003$), and motivating learners toward self-directed study ($p = 0.0001$). Residents and interns ($n = 14$) reported significant increases in confidence learning geriatric concepts, with pre- to post-session gains ($p = 0.027$), highlighting the dual benefit of the intervention.

Conclusions: Integrating a directly observed teaching activity with standardized feedback into routine clinical service is feasible and effective. Fellows reported increased confidence and measurable improvement in teaching skills, while residents demonstrated enhanced confidence in learning geriatric concepts. This model supports fellows’ development as educators and may serve as a framework for other geriatrics training programs.

A170

Language Matters: Translating the Age-Friendly 4M Framework Into Hebrew

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Background: Israel ranks fourth among OECD countries in life expectancy, emphasizing the need for effective geriatric care strategies. In 2024, the Ministry of Health and JDC-Eshel launched the MEITAV Program to prevent functional decline and delirium during hospitalization, aligning with global age-friendly initiatives and the 4M framework adopted by major systems like the U.S. Veterans Affairs. Despite this, the 4M approach is not widely recognized by Israeli non-geriatric providers. Recognizing the multicultural nature of the Israeli health system but acknowledging Hebrew as the primary language of professional communication, we translated the 4M framework into Hebrew, aligning it with the local context.

Methods: Multiple Hebrew terms for each domain were explored, with consultations involving geriatrics and language experts, to preserve clarity and a memorable acronym while ensuring cultural and linguistic accessibility.

Results: The Hebrew version preserves the four-domain concept using words beginning with the letter *Tav*: *Takhlit* (Purpose/What Matters Most), *Tnua* (Mobility), *Tvuna* (Mentation/Wisdom), and *Trufa* (Medication). For the 5th M, Multicomplexity, we selected *Tmuna Gdola* (Big Picture), reflecting complexity and a holistic approach.

Discussion: This translation establishes a shared, culturally relevant foundation for age-friendly care in Israel, supports education and implementation, and offers a lens on the alignment between the 4Ms and Geriatric 5Ms. Future developments may include culturally adapted translations into other languages.



Top – “4 Tavim” Hebrew figure. Bottom – the correlating English terms

A171

Teaching delirium concepts to student volunteers to support early delirium intervention in emergency department settings

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Background: Research has shown that prolonged lengths of stay (LOS) in the emergency department (ED) can increase the risk of delirium. Furthermore, delirium in the ED can lead to longer hospital stays and increased mortality. In 2017, 19% of academic hospital ED visits for older adults aged 65+ had a LOS greater than 8 hours but

increased to 30% in 2024. With this increase in prolonged LOS, there is significant risk for poor outcomes among older adults. Despite this, there is lack of standardization in delirium education for health professional and pre-professional students.

Methods: This project is being implemented at a tertiary academic center. With leadership supportive of improving delirium management and working toward an Age-Friendly Health System (AFHS), we are leveraging existing volunteer resources to offer multi-component, non-pharmacologic interventions to reduce or prevent delirium. Undergraduate, post-baccalaureate, and pre-clinical nursing and medical students participated in workshops each consisting of three parts: a delirium overview, screening for delirium with 4AT, and non-pharmacologic strategies for delirium prevention. Pre and post-tests were used to evaluate knowledge before and after each workshop.

Results: 16 students participated with 14 completing both the pre-and post-tests to date. None of the students had prior exposure to delirium education. The average knowledge scores increased from 77.6%, SD = 19.2% to 89.8%, SD = 13.1%. All participants learned core components of non-pharmacologic interventions including orientation, encouraging mobility, providing a nurturing environment, and engaging in therapeutic activities.

Conclusions: There is lack of standardization in delirium education for health professional students with even less exposure among pre-professional students. Most delirium teaching targets clinical students or resident physicians to better prepare them to care for patients with delirium. As hospitals move towards AFHS, offering delirium training to volunteers already familiar with the system can be an effective way to expand staffing capabilities and support early intervention for delirium reduction in ED settings.

A172

Teaching Patient Priorities Care: A Pilot for Internal Medicine Residents

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Background

Older adults with multiple chronic conditions (MCC) often face complex, fragmented care. Patients with MCC differ in their priorities, and disease-siloed approaches do little to address tradeoffs and what patients are willing to do to achieve their health goals. Patient Priorities Care (PPC) is an evidence-based framework that anchors decision making and communication in individualized patient priorities. A PPC microskills curriculum has been developed with an inter-professional group of national educators to teach priorities-aligned decision making.

Methods

We will pilot a PPC microskills curriculum with IM Residents at a tertiary academic hospital with both categorical and primary care programs (n=160 residents). Sessions will focus on skills such as identifying patient values, translating values into health goals, and identifying tradeoffs, emphasizing how these skills can improve care for older adults with MCC. Residents will complete pre- and post-session surveys assessing satisfaction with the curriculum, confidence in each microskill, and intentions for clinical practice change, as well as feedback for iterative refinement.

Results

In a pilot with 23 trainees, a PPC microskills curriculum significantly increased learners' confidence in their ability to transform patient values into health goals, clarify what patients are willing to do

and determine which interventions to start or stop to address their top priority. Seventy-nine percent reported increased motivation to change their clinical practice after the session, suggesting strong educational value and feasibility for wider implementation.

Conclusions

A microskills-based curriculum in priorities-aligned decision making packages PPC content into skill-focused learning modules that increase confidence in core PPC skills and motivation to make clinical practice change. Based on these results, we will expand and disseminate this curriculum across interdisciplinary learner groups to equip clinicians with the skills to transition from disease-siloed to health priorities-tailored care.

A173

Comprehensive Care for Older Adults with HIV: The Importance of a Pharmacist's Medication Review

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Background: People living with HIV (PLWH) are aging. Many PLWH 50+ experience polypharmacy, defined as concurrent use of ≥ 5 medications including antiretroviral therapy. The Comprehensive Program of Integrated Care for Older Adults with HIV at Mount Sinai in New York City provides geriatric consultations to PLWH 50+ utilizing an interdisciplinary team (IDT) approach including a pharmacist-led Comprehensive Medication Review (CMR) to complete a medication reconciliation and identify strategies for medication optimization. Our goal was to assess the prevalence of polypharmacy after CMR, anticholinergic burden score, number of class D or higher drug-drug interactions (DDI), and number of medication management interventions to examine the importance of pharmacists in the care of PLWH 50+.

Methods: This was a single-center retrospective analysis of patients who received a CMR at a visit to our HIV-geriatrics program from April to Oct 2025. We calculated the number of medications before and after CMR, average anticholinergic burden score, number of class D or higher DDI, and number of medication management interventions.

Results: 142 CMR were completed across 105 patients with average age 69. The average number of medications was 16 +/- 7 before vs 14 +/- 6 after CMR. The prevalence of polypharmacy was 99.3%. The average anticholinergic burden score was 3 +/- 2.5. A total of 400 class D or higher DDI were identified, averaging 3 +/- 4 per CMR. 226 medication management interventions were recommended, averaging 2 +/- 1.8 recommendations per CMR including counseling patients.

Conclusion: A pharmacist-led CMR is important to provide an accurate medication reconciliation, identify the anticholinergic burden of medications which has adverse effects in older adults, and identify DDI in this population of PLWH 50+ with multiple comorbidities. Pharmacists working on the IDT provide medication management recommendations to optimize patient care and adherence to treatment. Our model is unique in that a pharmacist is embedded in the geriatrician-led IDT delivering care to PLWH 50+ in the HIV primary care clinic. Future studies of pharmacist-led interventions on patient related outcomes are necessary to build the evidence base for the important role of pharmacists in the care of PLWH 50+.

A174

Second Phase of Enhancing Advance Directive Completion Among Older Adults in the Geriatrics Clinic in Indiana, USA: A Quality Improvement Initiative

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Background: Advance care planning supports patient autonomy in future medical decision-making, yet national completion rates of advance directives (ADs) remain low, particularly among older adults and underserved populations. The geriatrics clinic at Indiana University Health Primary Care (IUHPC) demonstrated similarly low documentation. This quality improvement initiative aimed to increase AD completion among adults aged ≥ 65 years and meet and exceed the national average of 46% completion.

Methods: A two-phase intervention (September-November 2024; January-June 2025) was implemented during Tuesday clinic sessions. Eligible patients were ≥ 65 years old with at least one visit between April 2024 and June 2025. Medical assistants introduced AD forms during rooming using a standardized script, followed by physician-led discussions with educational materials in English and Spanish. AD status was determined through manual review of the Cerner electronic medical record (EMR), including structured fields, documentation, and scanned forms. The primary outcome was the proportion of visits with completed AD pre- and post-intervention. Fisher's exact and chi-square tests were used to compare proportions. Demographic data, including race/ethnicity, were abstracted from the EMR.

Results: A total of 127 unique visits were analyzed (45 pre-intervention; 82 post-intervention). The patient population included older adults with racial/ethnic diversity reflective of the clinic's underserved community. Baseline AD completion was 11.1% (95% CI 4.8-23.5%). After the intervention, completion increased to 30.5% (95% CI 21.6-41.1%), an absolute improvement of 19.4 percentage points (Fisher's exact $p=0.016$). Logistic regression demonstrated a 3.51-fold increase in odds of AD completion post-intervention (95% CI 1.24-9.95, $p=0.018$). Phase-specific rates rose to 56.8% in Phase 1 and 66.4% in Phase 2. Monthly rates fluctuated but consistently exceeded baseline.

Conclusions: A structured, team-based workflow using standardized scripts, patient education, and consistent EMR review significantly increased AD completion among older adults. Sustained implementation and system-level support may further enhance uptake and equity in advance care planning.

A175 Encore Presentation

30-Day Emergency Department Utilization among Post-Acute Skilled Nursing Facility Patients after Declaration of the Public Health Emergency due to Covid 19.

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Background: Patients discharged to Skilled Nursing facilities (SNF) for post-acute care are predisposed to unplanned health-care utilization. This situation was compounded by the COVID 19 pandemic and consequent declaration of the Public Health Emergency (PHE) in March 2020 when SNFs faced unique challenges and clinical providers often switched to telemedicine visits. We conducted this study to evaluate changes in 30-day Emergency Department (ED) utilization among post-acute SNF patients following PHE declaration.

Methods: We retrospectively evaluated institutional billing records for SNF admissions between October 1, 2019, and June 30, 2021, to identify the study cohort. Demographic and clinical variables and outcomes were obtained from administrative databases and the electronic health record. After completing propensity score matching, we conducted an interrupted time series analysis to compare 30-day ED visit rates before and after PHE declaration.

Results: There were 7,103 SNF admissions during the study period of which 82% were 65 years or older. Overall, 1501(21.1%) SNF admissions needed ED care within 30 days. Despite a decline in the first week, overall, 30-day ED visit rates did not change significantly with pre and post PHE rates being 21.2 and 19.9 % respectively (p value=0.31).

Conclusions: There was no significant change in 30-day ED utilization in this cohort of SNF patients following PHE declaration. This is important because SNF care was particularly impacted during the pandemic. Though these results need to be confirmed in larger populations over different geographic areas, they indicate a need to evaluate telemedicine use in this setting when in-person visit is not possible or may delay care.

A176

Functional Capacity Decline and its Determinants in Older Adults Attending a Geriatric Oncology Service at a Tertiary Care Hospital in Eastern India

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Introduction:

The concept of intrinsic capacity (IC), proposed by the World Health Organization, offers a multidimensional approach to evaluate the overall functional reserves of older individuals. Among older adults with cancer, functional decline is often accelerated due to both disease and treatment related stressors. However, the pattern and burden of IC impairment in geriatric oncology settings remain insufficiently characterized.

Methods:

A cross sectional study was conducted at Medical College Kolkata over one year involving 231 patients aged > 60 years, selecting using systematic random sampling. IC domains were assessed using: Mini-Mental State Examination, Geriatric Depression Scale-15, Mini Nutritional Assessment -Short Form, Timed Up and Go Test, and self reported vision and Whisper test.

Results:

IC impairment was found in 95.24% of participants. Psychological health (78.8%), Mobility (51.1%), and Cognition (43.7%) were most frequently affected. Lower education level was correlated with cognitive impairment ($p<0.001$) and vision impairment ($p<0.01$). Lung disease and sleep disturbances were associated with poor nutritional status, cognition decline, and increased fall risk. Depression significantly increased fall risk ($p<0.001$).

Conclusion:

Intrinsic capacity impairment is highly prevalent among geriatric cancer patients, largely driven by deficits in mental health, mobility and cognition. Routine IC assessment early targeted intervention focussing on nutrition, mental health, locomotive support and sensory impairment are essential to improve patient outcomes in geriatric oncology service.

A177

Gabapentin in Colorectal Surgery: A National Survey of Prescribing Practices

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Gabapentin (gb) is largely used as a postoperative analgesic (PA). But, limited data exist on its safety and risks among colorectal surgery (CRS) patients. A survey distributed via email to members of the American Society of Colon and Rectal Surgeons and advanced practice providers (APPs) between Jun-Jul 2025 aimed to analyze prescribing practices related to PA use in CRS patients. Inclusion criteria: $\geq 50\%$ inpatient CRS practice. Data was analyzed using SAS software; chi-square and Fisher's exact tests were used where

appropriate. Of 167 responses (17% response rate), 120 met inclusion criteria: surgeons (68%), APPs (3%), and 29% unknown. 27% were female, 51% aged 31–50, 45% White, and 43% had ≥ 10 yrs of experience (exp). The most commonly prescribed PAs were acetaminophen (91%), opioids and NSAIDs (both 82%), gb (60%), and topical anesthetics (35%). Factors influencing PA modification included: Opioids—delirium or age >85 (both 45%), dementia (44%); gb—age >85 (46%), delirium/dementia (39%), frailty (25%). All respondents reported using gb postop, and 55% reported frequent use. Key factors influencing gb dosage included: No dose—delirium (62%), dementia (60%), age >85 (53%); Low dose (100 mg)—frailty (49%), renal impairment (40%), >3 comorbidities (35%); Moderate dose (300 mg)—high-risk CRS (54%), general anesthesia (51%), ≥ 3 comorbidities (33%). Common side effects were sedation (57%), delirium (53%), and dizziness (38%). Among 81 respondents noting side effects, 86% reduced or discontinued gb, and 3% consulted medicine. Post-discharge, 57% discontinued gb, 31% continued it, and 9% adjusted dosage. Gb was considered beneficial for reducing opioid use (61%), providing analgesia (48%), decreasing ileus (25%), and shortening length of stay (18%). Exp level did not significantly affect familiarity or attitudes toward gb use (≤ 10 yrs: 62% vs ≥ 10 yrs: 61%, $p=0.9276$; positive attitude: 64% vs 55%, $p=0.3683$) but those with ≥ 10 yrs of exp believed gb's benefits outweighed its risks (80% vs 85%, $p=0.5614$), reduced overall postop opioid use (33% vs 41%, $p=0.4618$), and felt confident in managing its adverse effects (45% vs 58%, $p=0.2150$). Most CRS surgeons and APPs favor the use of gb and recognize both its benefits and potential adverse effects as a PA. Further research is warranted to evaluate the safe use of gb, particularly among vulnerable populations.

A178

Delirium Management Among Geriatric Patients in the NYU Emergency Department

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Delirium is a neurocognitive emergency that affects 6%–35% of older adults in the Emergency Department. It is frequently unrecognized and linked with increased mortality, increased hospital stays, accelerated cognitive decline, and higher rates of rehospitalization. Despite its impact, the ED environment often lacks effective tools and strategies to prevent or manage delirium.

At NYU, about 25,000 older adults are seen annually in the ED. The project aims to improve early identification, prevention, and management of delirium through routine delirium screening and targeted interventions, this study aims to improve delirium recognition, reduce its incidence and severity, and improve patient outcomes. This approach leverages an innovative model in which a Geriatric Nurse Practitioner is embedded in the ED, integrating geriatric expertise directly into frontline emergency care.

This descriptive observational study was conducted in the NYU ED from May to September 2025. A convenience sample of patients aged ≥ 65 , were screened for delirium using the validated Confusion Assessment Method (CAM). Screening occurred during the weekday afternoons and was performed by an embedded Geriatric NP. Demographic characteristics and CAM results were analyzed to determine the prevalence of delirium and associated factors.

A total of 214 older patients (mean age 87.4 ± 6.2 years) were screened, with 123 (57.5%) female and 23 (11%) screening positive for delirium. Five (2.3%) patients had indeterminate results, indicating up to 13% of patients likely to be discharged had possible delirium. The racial/ethnic distribution was 74.8% White, 8.9% Hispanic, 4.2% Black, 4.2% Asian, 0.9% Southern American Indian, and 7% declined to state.

Delirium remains a prevalent and underrecognized condition among older adults in the ED, with significant implications for patient outcomes. Our preliminary data demonstrates that routine delirium screening using the CAM tool is effective in identifying at-risk patients, aligning with national delirium prevalence rates in EDs. These results highlight the need for systematic delirium prevention and management strategies, including the implementation of validated nursing-led screening tools, geriatric-focused interventions, and the integration of geriatric expertise. Such efforts are critical for reducing delirium-related harm and improving the quality of care for older adults.

A179

Factors associated with older adults' preferences towards deprescribing in LMIC outpatient settings.

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Background: It is still not very clear what the factors that are associated with the patient's willingness to deprescribe. Therefore, the objective of the present study is to investigate factors associated with patient preferences toward deprescribing in Lebanon.

Methods: We are conducting a face-to-face patient survey that started in November and will continue till February 2025 among outpatients, older adults, and visitors at three tertiary hospital sites in Beirut, the capital city of Lebanon. We are collecting data on participants' demographics, clinical factors including number of comorbidities and home medications, self-related health, perceptions about their number of medications and polypharmacy, cognitive-functional status, number of adverse events, and health care utilization in the past 12 months. Besides, we are also examining the willingness of older adults to deprescribe based on 9 different vignettes on a patient with cardiovascular disease and another with a sleeping disorder with alternating risk of efficacy and adverse events. We will apply a multivariable logistic regression to examine the association between patient factors and willingness to deprescribe, controlling for variables that might affect the association, such as age, gender, and number of chronic medications.

Results: We are aiming to collect a total of 300 older adults during the data collection period. Results will be available at the time of the conference.

Conclusion: The results of this study can resolve inherent uncertainties and help in designing patient-centered intervention to improve patients' perception of polypharmacy and enhance their willingness to deprescribe.

A180 Encore Presentation

I Want To Hurt Less and Move More: What matters most in Geriatrics and Palliative Care

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Background The Centers for Medicare & Medicaid Services (CMS) launched the 2025 Age-Friendly Hospital Measures (AFHM) program to support the 4Ms (Matters Most, Mind, Medication, and Mobility) and promote goal-concordant care for older adults. Priorities may differ for relatively healthy older adults versus those with serious illness. This two-phase pilot explores "What Matters Most" (WMM) among hospitalized older adults and compares geriatrics with geriatric-palliative care (GeriPal) patients in Phase 1. Phase 2 expands this work with early, routine questionnaire administration to identify goals and guide interventions.

Methods Phase 1 used a prospective cross-sectional survey of hospitalized adults aged 65+ able to answer WMM questions. Geriatrics patients were recruited from a designated AFHM pilot unit; GeriPal patients from the palliative care consult service. The survey included three questions: Q1)What can we do to make your hospital day better? Q2)What are your healthcare goals? Q3)What matters most in life?. Demographics were collected, responses analyzed for themes and groups compared. Phase 2 will administer the questionnaire within three days of admission to support early mobilization, pain control, and goal-aligned care.

Results 51 patients participated: 51% geriatrics, 49% GeriPal; mean age 78 (65-102); 53% male; 39% required interpreters. Across all participants, top themes were Q1 pain control (22%); Q2 healthy recovery (31%); Q3 family (31%). Geriatrics patients most often reported "nothing additional" for Q1 (23%), while GeriPal patients prioritized pain control (32%). For Q2, geriatrics emphasized recovery (42%), whereas GeriPal patients prioritized going home (36%). For Q3, both groups identified family most often. Mobility appeared in both groups.

Conclusion Phase 1 shows that hospitalized older adults prioritize pain relief, recovery, and family connection. Differences between geriatrics and GeriPal patients suggest priorities shift with illness severity, underscoring the value of structured WMM conversations. Mobility remained universal. Phase 2 will assess whether early emphasis on mobility and pain influences priorities, discharge planning, and length of stay.

Reference Virdun C, Luckett T, Lorenz K, et al. *Palliative Medicine*. 2020;34(10):1402-1415.

A181

Acute Care NPs Increase Geriatrics Workforce Through 5Ms
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Background: Number of board-certified geriatricians is inadequate to meet the needs of older adults.

Method: Between 12/5/2022 to 3/29/24, specialized consults on hospitalized Medicare Advantage patients in an academic hospital occurred using age-friendly 5Ms principles: what matters; mind; mobility; medications and multi-complexity. For training, 13 hospitalist NPs each spent two weeks with a geriatrician learning about 5Ms. NPs received formal didactics on dementia, delirium, geriatric syndromes and comprehensive geriatrics assessments. After initial training, NPs conducted 5Ms consults with a geriatrician. Ongoing education occurred through hearing about cases admitted to inpatient geriatrics service and lectures for internal medicine residents on Medicare, levels of care, crucial conversations, dementia, delirium. NPs were surveyed on perception of age-friendly care after initial training and ongoing incorporation 3 months after consults concluded.

Results: None of the 13 NPs have gerontology certification; 11 have acute care certification and 2 have family practice certification.

After the initial training:

9 NPs responded. 8 of 9 report change in approach: more ageism awareness; importance of assessing function and mobility and addressing what matters and multi-complexity in context of social drivers of health. Prior to training, 2 of 9 considered what mattered. After training, 8 of 9 considered what mattered. 6 of 9 changed how they discuss plan of care and discharge planning.

Three months after conclusion of 5Ms:

12 NPs responded. As primary hospitalist discharge provider, 6 report they almost always (>75% of time) and 3 report that they often (50-75% of time) incorporate 5Ms. As primary hospitalist, 8 almost always and 4 often use 5Ms. On the observation unit, 5 almost always and 4 often use 5Ms. 11 NPs incorporate medications (91%), mind (91%), mobility (82%), what matters (82%), multi-complexity (82%). 7 of 10 reported lack of time as a barrier. 5 of 10 did not incorporate 5Ms when it was not appropriate (e.g. acutely ill) or not indicated

(no active issues). 9 of 12 report their approach to discharge planning changed since learning the 5Ms.

Conclusion: The geriatrics workforce can grow exponentially by having non-geriatrics trained acute care nurse practitioners (NPs) learn age-friendly principles from inpatient geriatricians. Immersion in the care of older adults with structured geriatrics didactics improves competence in caring for older adults.

A182

Geriatric Care Competencies Among Clinicians Serving Older Adults Experiencing Homelessness and Substance Use Disorders
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Background: Older adults (OA) with lived experience of homelessness (LEH) and substance use disorders (SUD) face unique vulnerabilities as they age and often receive care in settings with limited access to geriatric specialists. We aimed to assess geriatric care competencies among interdisciplinary clinical and social services staff serving OA-LEH and OA-SUD in community contexts.

Methods: To prepare Grand Rounds sessions at three urban agencies serving OA-LEH and OA-SUD, we developed and administered an educational needs-assessment survey to clinicians and social services staff. We subsequently conducted an IRB-approved secondary data analysis of these survey data to describe perceived care challenges and training priorities in this workforce. The survey assessed knowledge and skills related to key geriatric care domains: the 4Ms of mobility, medications, mentation, and what matters most, as well as uses of telehealth. Survey items were adjusted slightly for different respondent roles and care settings. Descriptive statistics were used to summarize knowledge-based strengths and weaknesses.

Results: 68 respondents completed the survey (24=MD; 3=PA; 17=NP; 5=RN; 2=LPN; 1=psychologist, 3=counselors; 2=LCSW; 11=case managers without clinical degrees; 4 participants hold sub-specialty geriatrics training). 87% reported that ≥25% of their case load were older adults. 67% of clinical staff reported their confidence in conducting cognitive evaluations was less than ideal. Reported strengths include competence in deprescribing and familiarity with lifestyle approaches for mentation and mobility impairment. Reported gaps include conducting cognitive evaluations, assessing mobility impairment, prescribing ambulatory devices, and assessing patients' telehealth readiness. We provide a detailed analysis of survey results including common beliefs and misconceptions in caring for older adults.

Conclusion: Meaningful gaps in geriatric care competencies among community-based clinicians and social services staff caring for OA-LEH and OA-SUD worsen existing health disparities in this patient population. We recommend strategies to enhance geriatrics education for this critical workforce, including structured cognitive assessment training and targeted education on mobility and telehealth needs of older adults.

A183

How Can We Help? Incorporating Geriatrics into an Interdisciplinary Clinic Caring for People with HIV
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Background: People with HIV (PWH) experience increased rates of geriatric syndromes and accelerated aging. Geriatricians expertly manage these conditions, but optimal approaches for incorporating their services into routine HIV care remain undefined. In preparation

for adding a geriatric medicine consultation service to a large interdisciplinary clinic providing care for PWH in Tennessee, we assessed HIV provider interest in assistance with diagnosis and management of geriatric syndromes.

Methods: We developed and distributed an anonymous REDCap survey to providers at a quaternary academic medical center's interdisciplinary clinic caring for PWH. The survey asked providers their interest in geriatrician consultation and their current comfort managing geriatric syndromes and related conditions. Syndromes assessed were organized by each of the 5Ms, and for each condition providers selected from the following responses: "I am interested in help with diagnosis," "I am interested in help with management," and "I am already comfortable with diagnosis and management". An additional survey asked about provider interest in further resources about HIV and aging.

Results: In total, 8/19 (42%) providers completed the survey. All providers (n=8) reported an in-clinic geriatric consultation would be very (n=5) or somewhat (n=3) helpful. The syndromes with the highest number of respondents signaling interest in help diagnosing and managing were related to Mind (n=8). The condition with the highest proportion of providers reporting current comfort with diagnosis and management was related to Medication (n=5). Additional resources that respondents were most interested in included connection to community resources for older adults (n=7) and a recurrent interdisciplinary conference to discuss challenging cases (n=5).

Conclusions: Among HIV providers at a large interdisciplinary HIV clinic, all respondents reported in-clinic geriatric consultation would be helpful, with cognitive and mental health conditions identified as areas of broadest concern. Future directions include assessing the needs and priorities of older PWH with the ultimate goal of designing the most effective consultation service.

A184

Penn State Emergency Medicine CarES: Characterizing the Stress of Care Partners for People with Dementia in the ED

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Background: Unpaid family care partners (CPs) provide most care received by people living with dementia (PLWD) at home. CPs experience and manage many stressors on their own.

Objective: To characterize the stress of CPs of PLWD who were evaluated and discharged home from the emergency department (ED) at the ED visit and at 3 and 6 months.

Methods: This was a secondary analysis of data from a cohort of 31 PLWD-CP dyads recruited for a pilot study on the relationship between CPs' stress levels and return visits of PLWD to the ED over 6 months. Participants were recruited from a level 1 trauma center ED in south-central PA, October 10, 2024 to April 23, 2025. CPs completed 2 stress screens: a 3-item version (ZBI-S) of the Zarit Burden Interview (ZBI), scored 0-12, and a stress thermometer (ST), scored 0-4, at 0, 3, 6 months, with higher scores indicating higher stress. We conducted quantitative and qualitative analyses. Descriptive statistics summarized cohort characteristics and stress levels. Qualitative analyses employed Grounded Theory Approach to identify and interpret narrative themes informed by CPs' responses to the 3 "most stressful caregiving-related things" and resources needed.

Results: Most (58%) PLWD had mild dementia. Most CPs were spouses (67%) or (grand) children (26%). Mean ZBI-S and ST scores in the ED were 5.87 (range 2-11) and 2.5 (range 0.5-4), respectively, with

(grand) children CPs reporting higher stress than spouses (6.9 v 5.6). Mean time to complete the ZBI-S and ST in the ED was 72 and 296 seconds, respectively. Five themes emerged (the weight of CP burden, difficulty navigating disease progression, systems-based struggles, gaps in knowledge, search for support and relief) from 270 stressors ("If you don't have the money to pay for what you need, what do you do?") and resources needed listed by CPs.

Conclusion: CP stress screens can be done quickly (1-5 minutes) in a busy ED. Most CPs of PLWD coming from home report moderate stress. Thematic analyses of stressors will inform interventions and resources that target the major contributors to each CP's stress.

A185

Baseline frailty and glucocorticoid duration in an inception cohort of older adults with polymyalgia rheumatica

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Background

Prolonged Glucocorticoid (GC) use is common in patients with Polymyalgia rheumatica (PMR), a condition that primarily affects older adults. Although frailty is prevalent in patients with PMR, its association with duration of GC treatment is understudied. This retrospective cohort study examined the association between baseline frailty and GC treatment duration in older adults with incident PMR.

Methods

Using medicare claims from 2016–2022, patients aged ≥66 years with a new diagnosis of PMR were included if they had: 1) ≥1 inpatient or ≥2 outpatient claims for PMR (ICD-10-CM M35.3) within 30–365 days, 2) GC prescriptions of 7.5–30 mg/day within 30 days of diagnosis and cumulative use ≥200 mg over ≥120 days, and 3) ≥1 year of baseline and ≥2 years of follow-up enrollment. Frailty was measured using a validated claims-based frailty index during the baseline.¹ Outcome of interest was GC discontinuation (i.e., no prescription for ≥3 months). Sequential multivariable adjusted hazard ratios (aHR) and 95% confidence intervals (CI) were calculated using Fine and Gray competing risk models to account for death. Analyses were stratified by time period: the first year and years 2–5, to avoid proportional hazard violations.

Results

Among 17,695 patients, 30.7% were non-frail (n=5435), 56.7% pre-frail (n=10,041), and 12.6% frail (n=2219). Mean (SD) age was 77.9 (6.8) years, 91.5% were White, and 60.7% female. During follow-up, 1,256 deaths occurred (682 pre-frail, 464 frail).

In the first year, frail (aHR 1.20, 95% CI 1.10-1.30) and pre-frail (aHR 1.07, 95% CI 1.02-1.12) patients were slightly more likely to discontinue GC compared to non-frail. However, in years 2-5, frail (aHR 0.34, 95% CI 0.30-0.39) and pre-frail patients (aHR 0.73, 95% CI 0.68-0.77), were significantly less likely to discontinue GC. GC-sparing agents were prescribed in only 3.61% of patients during follow-up.

Conclusions

In older adults with incident PMR, frailty was strongly associated with prolonged GC use beyond the first year.

References:

1. Kim DH. J Gerontol A Biol Sci Med Sci. 2018

Multivariable adjusted hazard ratio for baseline frailty and GC duration

	Model 1: (age & sex)	Model 2: (model 1 + race, dual eligibility, social vulnerability index, and rural-urban status)	Model 3: (model 2 + Charlson Comorbidity Index, obesity, osteoporosis, medications, GC daily dose, and number of primary care visits)	Model 4: (model 3 + analgesics 90 day baseline)
	HR (95% CI)	HR (95% CI)	HR (95% CI)	HR (95% CI)
First year follow-up, Frailty (mild, moderate, severe) (Ref. No frailty)	0.96 (0.90-1.03)	1.05 (0.98-1.12)	1.06 (0.99-1.14)	1.20 (1.10-1.30)
First year follow-up, Pre-frail (Ref. No frailty)	0.99 (0.95-1.03)	1.03 (0.99-1.07)	1.03 (0.99-1.08)	1.07 (1.02-1.12)
Second year follow-up, Frailty (mild, moderate, severe) (Ref. No frailty)	0.28 (0.25-0.31)	0.30 (0.27-0.34)	0.30 (0.27-0.34)	0.34 (0.30-0.39)
Second year follow-up, Pre-frail (Ref. No frailty)	0.67 (0.63-0.70)	0.70 (0.66-0.74)	0.70 (0.66-0.74)	0.73 (0.68-0.77)

HR = hazard ratio; CI = confidence interval

A186

Improving EMS Preparedness for Older Adults: Outcomes of Dementia and Age-Friendly Training for Emergency Responders
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Background:

Older adults increasingly utilize Emergency Medical Services (EMS), requiring specialized knowledge in geriatric and dementia care. The City of Fort Worth Fire Department (previously MedStar Mobile Healthcare), serving over one million residents in Fort Worth and 14 surrounding cities, partnered with The University of North Texas Health Science Center to enhance dementia-friendly and age-friendly EMS practices. The objective was to evaluate the impact of training community paramedics and emergency medical technicians (EMTs) in evidence-based tools and strategies that improve safety, communication, and care coordination for older adults.

Methods:

A dementia and age-friendly training was completed by 406 MedStar EMTs and community paramedics. The dementia training evaluation survey measured perceived knowledge, confidence, and skill application using a 5-point Likert scale. Responses were analyzed descriptively to assess knowledge gains and training satisfaction. Participant demographics included a racially and ethnically diverse EMS workforce representative of the greater Fort Worth area.

Results:

A total of 406 survey responses were analyzed across 13 items. The majority of participants found the training useful (80% agree or strongly agree), greater knowledge of how to use a dementia screening tools (84% agree or strongly agree), and greater understanding of the importance of assessing for dementia in older adults (88% agree or strongly agree).

Conclusions:

Integration of dementia-friendly and age-friendly principles into EMS training enhances workforce preparedness and patient outcomes for older adults. Findings support ongoing investment in EMS-based dementia education and highlight the value of partnerships between academic institutions and emergency healthcare systems to expand community-based dementia support.

A187

Can the FI-CGA-10 Reliably Predict Emergency Department Visits within Six Months of Chemotherapy Initiation and One-Year Mortality in Older Adults with Cancer?

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Introduction:

Older adults with cancer exhibit different responses to chemotherapy and variable risks of adverse outcomes due to their heterogeneity. FI-CGA-10, a 10-item frailty index derived from CGA domains, offers an approach to quantifying frailty severity and is used as a part of prechemotherapy assessment of older adults with cancer. This study aims to evaluate the effectiveness of the FI-CGA-10 in predicting negative outcomes from chemotherapy.

Methods:

We conducted a retrospective cohort study of adults aged ≥ 65 years evaluated at the Geriatric Oncology Multidisciplinary Clinic (GOMDC) at Rhode Island Hospital between January and June 2023. We extracted demographic and clinical characteristics, and frailty measures (including FI-CGA-10 data) from the electronic health record. The primary outcome was any ED visit within 6 months of the initial GOMDC evaluation. The secondary outcome was 1-year mortality. Descriptive statistics summarized patient characteristics, and Chi-square, Fisher exact, and Wilcoxon tests calculated associations between FI-CGA-10 categories and outcomes (SAS version 9.4).

Results:

Of 20 consecutive older adults attending GOMDC we reviewed, 9 (45%) experienced ≥ 1 ED visit within 6 months of the GOMDC visit. Among those classified as very fit by FI-CGA-10, 22% had an ED visit ($p = 0.5658$). ED utilization did not differ significantly between moderately and severely frail patients. At 1-year follow-up, five patients (26%) had died. FI-CGA-10 scores were higher among patients who died within one year compared with survivors (median rank: 13.1 vs. 8.9), though not significant (Wilcoxon $p = 0.162$).

Conclusion:

In this pilot cohort of older adults with cancer, FI-CGA-10 indicated a tendency to predict clinically important 1-year mortality, with all deceased patients within 1 year categorized as severely frail. The direction of effect suggests a potential prognostic signal, aligning with the finding that all deaths occurred among severely frail individuals. This finding highlights the importance of structured geriatric assessment in uncovering vulnerabilities in older adults with cancer and supports the use of FI-CGA-10 as a pragmatic frailty tool in geriatric oncology care.

A188

Frailty and Hip Fracture Outcomes in Older Adults during the COVID-19 Era: Insights from the National Inpatient Sample

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Background: Hip fractures are a major public-health problem in older adults. Prior studies have highlighted that frail older adults have a higher incidence of hip fractures, yet studies fail to elucidate the prevalence of associated frailty indices. Large-scale data on the impact of frailty on hip fracture during COVID-19 era (2020-2022) remains limited. We aim to address this gap by analyzing a nationally representative cohort of hospitalized older adults with hip fracture using the National Inpatient Sample. Methods: We used the 2020-2022 NIS to identify hospitalization for hip fractures in patients aged ≥ 65 years. Hip fractures were compared among individuals who were frail vs. non-frail. Frailty was defined using the Johns Hopkins Adjusted

Clinical Groups frailty indicators; patients were classified as frail if at least one frailty indicator was present. Inpatient comorbidities were compared, using chi2 for categorical and t-test for continuous variables. Multivariable linear regression was performed to identify factors independently associated with length of stay, mortality and total charges. Results: A total of 202,640 patients aged ≥ 65 years with hip fracture were identified. Overall, 189,168 (93.4%) were classified as frail and 13,472 (6.6%) as non-frail. Frail patients were more often females (68.6% vs 59.3%, $p < 0.001$) and in age group 85-95 (41.0% frail vs. 25.3% non-frail, $p < 0.001$). White race was the predominant race in both groups and Medicare was main payer in both groups (90.5% frail vs 86.1% non-frail). Mean LOS was 6.46 vs 6.26 days for frail and non-frail patients, respectively. Among frail patients, most common frailty components were falls (91.9%), dementia (29.0%), incontinence (15.1%) and malnutrition (9.7%) (all $p < 0.001$). Comorbidities more frequent in frail group included: congestive heart failure (19.6% vs 18.4%, $p < 0.001$), renal disease (23.8% vs 20.5%, $p < 0.001$) and acute COVID-19 infection (3.2% vs 2.4%, $p < 0.001$). In multivariable regression, mobility difficulties (+3.1 days, $p < 0.001$), pressure ulcers (+3.0 days, $p < 0.001$), COVID-19 infection (+2.9 days, $p < 0.001$) were among the factors most strongly associated with increased LOS. Conclusion: Frailty was highly prevalent among older adults with hip fractures and was associated with greater comorbidity burden and slightly longer hospital LOS.

A189

Diabetes and HFpEF are Major Predictors of Stroke in Elderly Patients with Atrial Fibrillation: An Anticoagulant-Naïve Population Study

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Objective:

To identify clinical predictors of ischemic stroke in elderly atrial fibrillation (AF) patients (≥ 75 years) who are not receiving oral anticoagulation, with particular focus on the contribution of comorbidities such as diabetes mellitus (DM) and heart failure with preserved ejection fraction (HFpEF) in this anticoagulant-naïve population.

Research Design and Methods:

We conducted a retrospective cohort study using data from the National Taiwan University Hospital Integrated Medical Database, including AF patients aged ≥ 75 years without prior stroke or transient ischemic attack. Patients were stratified by OAC use. Multivariable Cox proportional hazards models were used to identify independent predictors of ischemic stroke.

Results:

Among 5,892 anticoagulant-naïve patients, both DM (HR 1.33; 95% CI 1.09–1.62; $P = 0.005$) and HFpEF (HR 1.50; 95% CI 1.19–1.87; $P < 0.001$) were independently associated with increased risk of stroke. In contrast, among 3,830 patients receiving OAC therapy, only female sex was significantly associated with stroke (HR 1.18; 95% CI 1.001–1.38; $P = 0.048$), while DM and HFpEF were not.

Conclusion:

In elderly AF patients not receiving anticoagulation, DM significantly increases the risk of ischemic stroke, particularly when coexisting with HFpEF.

A190

Influence of Mobility on Recovery and Discharge Outcomes Among Older Adults Undergoing Inpatient Endoscopic Procedures

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Background:

Mobility is key for recovery after surgery, but its influence after inpatient endoscopic procedures is unknown. We aimed to assess how mobility impacts outcomes.

Methods:

We conducted a retrospective cohort study of patients aged > 65 years admitted to our center who underwent endoscopic procedures between 2021 & 2025. Mobility was assessed using ADL and BMAT scores. Multivariate logistic regression was used to identify predictors of discharge disposition and 30-day readmissions.

Results:

Among 6,956 patients (mean age 77.10 ± 7.37), baseline mobility impairment was present in 68.18%. AR placement increased with female sex, longer post-procedural LOS (pLOS), and ADL $\geq$ baseline, and decreased among men, minorities, and higher baseline or discharge ADL & BMAT. SNF discharge increased with older age, longer pLOS, and higher CCI, and decreased in minorities, longer procedure duration, or higher baseline and discharge ADL & BMAT. LTCH discharge increased with longer pLOS and decreased with higher baseline and discharge ADL & BMAT. Higher CCI, pre-procedural anemia, and longer pLOS predicted 30-day readmission, whereas pre-procedural nausea and higher discharge BMAT were protective. Longer procedure duration was associated with increased pLOS.

Conclusion:

This highlights the importance of prioritizing endoscopic procedures and early discharge among older adults with multicomplex disease to avoid worse outcomes.

Multinomial Logistic Regression for Discharge Disposition

Predictor	OR (HH)	p (HH)	OR (AR)	p (AR)	OR (SNF)	p (SNF)	OR (LTCH)	p (LTCH)
Age	1.015	0.004	1.003	0.724	1.018	<0.001	0.995	0.729
Gender	1.108	0.169	0.52	<0.001	1.087	0.275	0.801	0.239
Race	0.965	0.313	0.767	0.001	0.806	<0.001	0.892	0.185
Procedure	0.985	0.503	0.961	0.403	1.005	0.816	1.039	0.354
Procedural duration (min)	1.001	0.691	1.001	0.751	0.994	0.039	1.007	0.119
Post-procedural LOS (d)	1.132	<0.001	1.18	<0.001	1.181	<0.001	1.166	<0.001
CCI	1.039	<0.001	1.007	0.68	1.024	0.012	1.033	0.166
ADL index (baseline)	0.947	0.043	0.879	0.001	0.924	0.003	0.798	<0.001
BMAT index (baseline)	0.975	0.63	0.789	0.003	0.909	0.059	0.911	0.386
ADL at discharge	0.842	<0.001	0.721	<0.001	0.728	<0.001	0.647	<0.001
BMAT at discharge	0.801	<0.001	0.783	0.012	0.538	<0.001	0.39	<0.001
ADL $\geq$ baseline at D/C	1.447	<0.001	1.741	0.006	1.106	0.397	0.999	0.998
BMAT $\geq$ baseline at D/C	0.856	0.164	0.871	0.457	1.007	0.948	1.403	0.213
ADL $<$ baseline at D/C	0.98	0.82	1.048	0.78	0.879	0.164	0.829	0.41
BMAT $<$ baseline at D/C	1.139	0.177	0.888	0.536	1.03	0.766	1.278	0.305

HH = Home Health; AR = Acute Rehab; SNF = Skilled Nursing Facility; LTCH = Long Term Care Hospital; LOS = length of stay; CCI = Charlson Comorbidity Index; ADL = activity of daily living; BMAT = Bedside Mobility Assessment Tool.

A191

Can Money Buy Happiness? Wealth and Life Satisfaction at the End of Life

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Background: Wealth is associated with longer lives and better health, but less is known about whether older adults with greater financial resources feel more satisfied as death approaches. We examined whether wealth is linked to life satisfaction at the end of life, and what factors are linked to low life satisfaction among the wealthy.

Methods: The study included 4,446 Health and Retirement Study (HRS) participants who died between 2000 and 2022 at age 65+ and were interviewed once in the last four years of life. Wealth was measured using the RAND household net worth variable at the last interview before death, categorized into deciles. Life satisfaction was assessed using a five-item Diener scale, capturing ideal life, life conditions, overall satisfaction, goal attainment, and regrets. Multivariable regression tested associations of wealth with life satisfaction after adjusting for demographics, health and function. Additional regression analyses identified factors associated with low life satisfaction among older adults in the top wealth decile.

Results: The mean age at death was 80.8 (SD 8.1); 51% were women, 82% were White. Overall, 70% of decedents reported being satisfied with their life, with satisfaction increasing with each wealth decile (Decile 1: 59%; Decile 5: 70%; Decile 10: 79%, p -value<0.001). These differences persisted after adjusting for age, gender, marital status, race or ethnicity, education, health and function (aOR (95%CI) per decile: 1.06 (1.03-1.09)). Among individuals with high wealth (top decile, wealth>\$983K), low life satisfaction was more common among those who were unmarried (73% vs 83%, p =0.021), functionally impaired (69% vs 82%, p =0.004), lonely (60% vs 82%), p =0.001), or who had low community engagement (68% vs 82%, p =0.004).

Conclusions: Wealth is strongly associated with life satisfaction at the end of life. However, even among wealthy individuals, low life satisfaction was common among those with impaired physical function and limited social connections, including being unmarried, having less community engagement, and feeling lonely. Interventions to enhance end-of-life well-being should consider wealth alongside targeted efforts to address physical disability and strengthen social connection, since money alone is unlikely to meet these needs.

A192

Evaluating the Risk of Sarcopenia in Older Adults Using GLP-1 Inhibitors

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Background:

Glucagon-like peptide-1 inhibitors, approved for diabetes management, promote weight loss and improve A1C by increasing insulin and reducing glucagon secretion. However, sarcopenia—a progressive, age-related loss of muscle mass and strength—is a significant concern and may be worsened in older adults, increasing frailty. Given these risks, we conducted a literature review to examine these adverse effects in older adults.

Methods:

Our research focused on review of multiple academic databases with use of key words such as “sarcopenia”, “frailty”, “older adults”, and “GLP-1 drugs”. In addition, with the use of our clinical librarian specialists, our team was able to locate about twenty related articles discussing sarcopenia as a potential risk of GLP-1 drug use.

Results:

The conducted literature search revealed inconsistent findings regarding sarcopenia as a potential adverse effect of GLP-1 drug use. Some sources reported little to no association between GLP-1 drug use and development of sarcopenia, while other sources indicated sarcopenia was evident at higher or specific doses of GLP-1 drugs. In addition, while these drugs have not been on the market that long, early conclusions were drawn about this sarcopenia related risk. Furthermore, our search showed a variety of articles listing sarcopenia-related effects in older adults taking GLP-1 inhibitors compared with standard of care. Our results also further suggest individualized monitoring programs for older adults on GLP-1 inhibitors with frequent visits for routine monitoring of adverse events.

Conclusions:

While evidence shows the benefits of GLP-1 inhibitors in the general adult population, greater attention is needed to their adverse effects in older adults. Additional research and systematic monitoring protocols are necessary to assess the risk of sarcopenia in this group, as its development can be life-threatening. Clinicians should closely monitor adverse events in older adults and carefully weigh the risks and benefits before initiating GLP-1 therapy.

A193

Trends in Overactive Bladder Medication Administration Among US Nursing Home Residents

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Overactive bladder and urinary incontinence are common conditions among nursing home residents. Anticholinergic medications can improve OAB/UI, but risks may outweigh benefits, especially for those with Alzheimer’s disease and related dementias. β_2 -adrenergic receptor agonists (mirabegon, vibegron) are newer, non-anticholinergic medications for OAB/UI, and may be preferred in nursing home settings; however, real-world administration of these medications is poorly described.

We conducted a serial cross-sectional study, by quarter, using electronic health record data from >24,000 US LTC facilities, supplied by PointClickCare. EHR data included electronic medication administration records, sociodemographic data, and Minimum Dataset assessments for residents receiving post-acute skilled nursing and LTC from Jan 1, 2015 - Mar 31, 2024. We used the first MDS assessment per quarter to assign each resident a study index date and identify ADRD. eMAR were used to identify OAB/UI medications administered within the quarter. We stratified residents by diagnoses of ADRD, OAB, and UI (eg, urgency, nocturia); and used logistic regression that accounted for autocorrelation to summarize relative changes in the prevalence of OAB/UI medications per year.

We identified 174,096 and 986,567 residents in Q1 and Q37, respectively. In Q37, mean (SD) age was 76.1 (12.7) years, 58.5% were female; 38.3%, 4.1%, and 8.25% were diagnosed with ADRD, OAB, and UI, respectively. Among residents who received ≥ 1 OAB/UI medication (6.0% and 7.4% in Q1 and Q37, respectively), oxybutynin was the most common, but its use declined over time from 63.4% to 52.0% (Q1-Q37). Among residents with ADRD, oxybutynin administration declined between Q21-Q37 by 3% per year (OR=0.97; 95% CI=0.96-0.98), whereas mirabegron administration increased by 6% (OR=1.06; 95% CI=1.05-1.07), and vibegron administration increased by 153% (OR=2.53; 95% CI=2.43-2.65).

In a large study of US nursing home residents, OAB/UI medication use patterns shifted over time toward increased β_2 -adrenergic agonists use, especially among residents with ADRD.

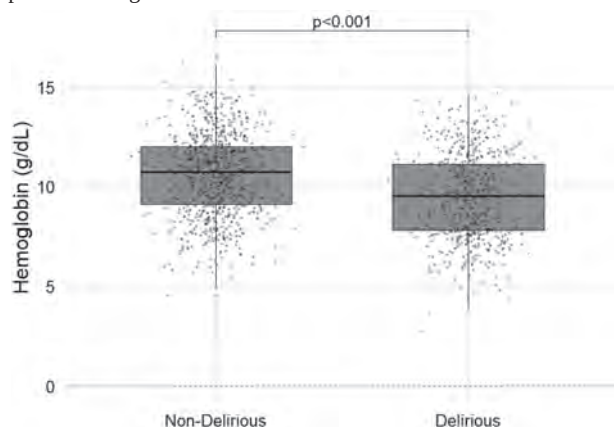
A194

Comparison of Anemia Severity Between Delirious and Non-delirious Cognitively Impaired Older Adults

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In previous studies, anemia in older adults has been shown to increase the risk of hospitalization and mortality. Among these hospitalized anemic patients, the likelihood of delirium, mobility issues, and falls greatly increases when compared to non-anemic patients. Therefore, a better understanding of the relationship between anemia and delirium is crucial to caring for older adults. This study aims

to explore differences in anemia severity between delirious and non-delirious patients. A retrospective chart review of 1,666 anemic, cognitively impaired patients was conducted. Data on age, hemoglobin levels, and patient cognitive impairments was abstracted. A Welch's t-test was performed using hemoglobin level (g/dL) as the dependent variable and delirium status as the explanatory variable. Of the patients, 928 were non-delirious while 728 were delirious and hospitalized. The abstracted sample consisted entirely of adults aged 59 and older. A t-test concluded that hemoglobin levels were significantly different between delirious and non-delirious patients ($p < 0.001$). Delirious patients had a hemoglobin level of 9.45 (95% CI: 9.29 - 9.61) g/dL compared to 10.56 (95% CI: 10.42 - 10.70) g/dL for non-delirious patients. Hospitalized, delirious patients in this study experienced significantly more severe anemia, which may be related to their delirium status. Acknowledging this difference could help in informing healthcare providers in selecting the appropriate treatment options to mitigate anemia in older adults.



A195 Encore Presentation

Multimodal Communication in Asymmetric Sensorineural Hearing Loss: AI-Powered Solutions for Older Adults

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Background:

Asymmetric sensorineural hearing loss (SNHL) poses complex challenges in palliative care settings, particularly for older adults with tumor-related deafness and multiple co-morbidities. Traditional amplification alone is often insufficient. A multimodal approach—integrating auditory rehabilitation, visual supports (e.g., speechreading, AI-powered captioning), environmental modifications, and psychosocial interventions—can improve clinical communication and quality of life for a large, vulnerable patient population.(1)

Case Presentations:

We describe two older adults with asymmetric SNHL. Case 1: Ms. T, a 74-year-old woman with profound right-sided SNHL secondary to acoustic neuroma and progressive contralateral loss, who underwent comprehensive rehabilitation including customized hearing aids, assistive listening devices, closed captioning, and ultimately right-sided cochlear implantation after extensive perioperative counseling. Case 2: Mr. R, a 90-year-old man with dissatisfaction from prior amplification, achieved improved communication following re-evaluation, feedback adjustment, and addition of speech-in-noise and T-coil programs.

Discussion:

Both cases illustrate how multimodal strategies—integrating auditory, visual (including speechreading and AI-powered closed captioning platforms such as live transcription apps), environmental,

psychosocial communication can optimize disease understanding, functional outcomes and support patient wellbeing. This mitigates listening fatigue, reduces social isolation, and preserves engagement in valued activities such as music, conversation and advocacy. Importantly, addressing communication barriers in the context of serious illness and co-morbidities highlights the urgency of embedding accessibility screening and multimodal communication strategies into advance care planning and serious illness discussions for older adults.

Conclusion:

These cases underscore the importance of early counseling, tailored technology use, and advocacy resources in ensuring meaningful participation and serious illness communication for improved quality of life in patients with asymmetric SNHL.

A196

Using Age-Friendly 5Ms to Elicit Comprehensive Needs of Hospitalized Medicare Advantage Patients

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Background: Incentives to care of hospitalized older adults differ in fee-for-service (FFS) and capitated models. Using age-friendly 5Ms approach for hospitalized older Medicare Advantage (MA) patients yields recommendations to address multi-complexity and utilization not typically considered in FFS.

Methods: Between 12/5/2022 to 3/29/24, specialized consults on hospitalized MA patients in an academic hospital occurred using age-friendly 5Ms principles: what matters; mind; mobility; medications and multi-complexity. The consult team included a geriatrician and a nurse practitioner. As the health system was preparing to implement its own MA plan starting on January 1, 2024, the health system medical group utilization management (UM) team referred inpatient MA patients identified as high risk for needing post-acute skilled nursing placement. The 5Ms consult team shared recommendations with UM, primary inpatient team, patient/surrogate and outpatient providers.

Results: From 12/5/2022 to 3/29/24, there were 25,443 hospital admissions of patients ≥ 65 years (65y). 1,554 were MA (6.1%). UM team referred 143 discrete consults (0.56% of total admissions ≥ 65 y; 9.2% of admitted MA). Of the 143, 7 were a repeat second admission. There were total of 743 recommendations. The top 10 recommendations for the 143 admissions were: Inpatient social work (48.9%); geriatric syndrome management (43.4%); level of care determination (43.4%); medical intervention recommendation (39.2%); inpatient physical therapy and occupational therapy consult (34.3%); presentation of advanced directives form (32.9%); inpatient geriatric pharmacist (28%); nursing intervention to increase mobility (25.2%); outpatient memory clinic referral (19.6%); education to family members (15.4%).

Conclusions: Dedicated age-friendly consult identifies the comprehensive needs of hospitalized MA patients. Both inpatient and outpatient multi-disciplinary teams are crucial to address all utilization contributors. Robust social work and connection to community resources is paramount to address the psychosocial concerns. Having one geriatrician provide support to multiple inpatient teams is a way to address geriatric syndromes and age-friendly medical interventions with limited supply of geriatricians. Access to outpatient memory evaluation is necessary to evaluate cognitive impairment. Incentives are necessary for inpatient providers to address advanced care planning.

A197

A Rare Case of Medication induced Walking Corpse Syndrome

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Objective:

To describe a case of corticosteroid-induced walking corpse syndrome (Cotard's syndrome) and persecutory delusions in an older adult, highlighting the increased sensitivity of this population to new medications due to age-related physiological changes.

Case Summary:

A 77-year-old female with end-stage kidney disease was admitted in an encephalopathic state. She had recently undergone an 18-day hospitalization for arteriovenous fistula creation, complicated by bacteremia and shock, requiring ICU admission, vasopressors, and systemic corticosteroids. During that admission, she developed delirium and acute psychosis, including delusions of being dead and persecuted. Quetiapine was started with intermittent benefit, but her psychosis worsened after discharge and medications were stopped. On re-admission, infectious, metabolic, and structural causes for her altered mentation were excluded. The patient required restraints and psychiatric consultation. Initiation of aripiprazole led to marked improvement within three days.

Discussion:

This case is discussed in the context of the "5 M's of Geriatrics": Mind, Mobility, Medications, Multi-complexity, and Matters Most. The acute psychosis was attributed to systemic corticosteroids, with delirium as a contributing factor. The use of antipsychotics and restraints introduced additional risks to her mobility and overall well-being. Decreased drug clearance, likely due to renal disease, may have resulted in higher corticosteroid levels, necessitating prompt discontinuation of the offending agent.

Conclusion:

Short-term systemic steroids are generally considered safe, but can precipitate severe neuropsychiatric effects in older adults. Distinguishing between delirium and psychosis in this population is challenging. Early recognition and management of medication-induced neuropsychiatric syndromes are essential to reduce morbidity and mortality.

A198

Feasibility of chair-based resistance exercises in older adults

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Background: Innovative ways to help older adults remain physically active may improve strength, balance, and mobility, while reducing bone loss and the risk of fragility fractures associated with osteoporosis. Although resistance training is the gold standard for enhancing muscular strength and function, traditional gym-based programs can be costly, time-consuming, intimidating, and often impractical for many older adults. We aimed to evaluate the feasibility of delivering a 24-week, at-home, chair-based resistance-band pilot training program for adults aged 60 years and older. **Method:** Patients from a bone health clinic were invited to participate in a 24-week home-based exercise study. Participants attended four in-person study visits. At the initial visit, study personnel provided instruction on eight chair-based resistance exercises using THERABand® resistance bands. Participants demonstrated each exercise and were instructed to perform the routine at home twice weekly, completing one set of 15 repetitions per exercise. Baseline assessments included frailty status, grip strength, gait speed, and balance measured using the Zibrio® stability score. Participants returned at 1, 3, and 6 months to re-demonstrate the exercises and repeat the assessments. Feasibility was defined as the proportion of participants who completed the exercises at least once per week in the study period. Study personnel contacted participants by phone each month between clinic visits to provide support. **Results:** Eleven women

were initially enrolled in the study. By the 3-month follow-up, seven remained active in the intervention. Of the four who discontinued, one requested withdrawal, two traveled outside the country, and one was lost to follow-up. Participants who remained in the program reported positive experiences during follow-up visits, noting that the exercises "made me feel stronger and my balance is better," "helped my grip strength," and that "my grandson has been helping me with the exercises." **Conclusion:** The program appeared feasible for participants who enrolled and remained in the study. However, those who chose to participate were generally highly motivated and ambulatory and thus may not represent the broader population of older adults who could benefit most from such an intervention. Additional research is needed to evaluate the program's effects on functional outcomes and bone health in a more diverse group of older adults.

A199

Balancing Frailty Risk and Weight Loss Goals: Risks of Novel Obesity Medications in a Cancer Survivor with Multimorbidity

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Background:

Older adults with obesity frequently experience cardiometabolic, mobility, and functional limitations impacting their quality of life. We present the case of a woman, who sought GLP-1 therapy to attain the target weight for surgery. She then sustained a fall with fracture, which impeded her progress to surgery.

Methods:

A 77-year-old post-menopausal woman with a history of breast cancer (post-aromatase inhibitor therapy), gastric bypass, multiple hospitalizations for heart failure, atrial fibrillation, spinal stenosis, back pain, insomnia, and osteoporosis. She had a high polypharmacy burden, including several weight-promoting medications. Her Clinical Frailty Score was 5 and she remained wheelchair-bound, with mobility and transportation challenges.

She was eager to start GLP-1 therapy to regain independence, reduce breast cancer and heart failure recurrence, and meet the goal weight for knee arthroplasty. After a shared decision-making process, which included review of increased risks for sarcopenia, bone loss, and worsening frailty, the lack of long-term safety studies was noted. Semaglutide was initiated and later switched to tirzepatide due to clinical indication and coverage challenges.

Results:

She achieved a significant 18.2% total body weight loss following initiation of GLP-1 therapy. (Fig 1). However, a subsequent fall and knee fracture, though not directly related to her medication, delayed her progress, highlighting her vulnerability.

Conclusion:

This case demonstrates the challenges of weight-loss pharmacotherapy in frail older adults with multimorbidity, underscoring the importance of shared decision making as emerging novel OMs are being approved for significant cardiometabolic comorbidities despite a lack of long-term safety data



Weight loss trend demonstrating a reduction from 291 to 241 lbs.

A200

Malnutrition Recognition and Its Association With Patient Outcomes in an Outpatient Geriatric Population

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Background:

Malnutrition is associated with increased morbidity and mortality in older patients in acute care settings. It is often underaddressed in the outpatient setting, with varying rates of screening, diagnosis, and intervention. The project's goal is to determine if a correlation exists between a formal diagnosis of malnutrition and/or abnormal weight loss and clinical outcomes defined as the number of hospital visits(HV) and length of stay (LOS).

Methods:

Retrospective chart review was conducted on patients aged >65 who were seen at an outpatient Primary Care Geriatric Clinic from June 1, 2023, to June 1, 2025. Data was collected for demographics, weight, Body Mass Index (BMI), comorbidities, number of HV, and LOS. Statistical analyses were performed using nonparametric methods, with significance defined at p<0.05.

Results:

Of 1335 charts reviewed, 341 patients had HV, and 235 had LOS data. HV and LOS were compared across three patient groups: 1) ICD-diagnosed malnutrition (IDM), 2) Electronic Health Record identified Malnutrition (EHRM) by abnormal weight change and BMI criteria, and 3) controls. Of the 353 patients with EHRM, only 52 patients had malnutrition and/or abnormal weight loss documented. The number of HV did not differ significantly among the groups (p=0.186). IDM (median 141hrs) and EHRM (median 98.5hrs) patients had significantly longer LOS (p=0.0023) than controls (median 74.0hrs), with post-hoc analysis showing no significant difference between the two malnutrition groups(p=0.067).

Conclusion:

Malnutrition and abnormal weight loss were associated with increased LOS. A substantial proportion of patients who met clinical criteria for malnutrition did not have a formal diagnosis, suggesting underrecognition in the outpatient setting. Implementing structured malnutrition screening and documentation may improve early identification of high-risk patients and support timely interventions to reduce adverse outcomes.

A201

Neighborhood disadvantage, physical function, and fall risk among older women with urgency urinary incontinence

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Background: Urgency urinary incontinence (UUI) in older women is linked to decreased physical function and increased fall risk, potentially exacerbated by socioeconomic disadvantage. We aimed to assess the level of physical function by neighborhood-level socioeconomic disadvantage, with the hypothesis that older women with UUI living in more disadvantaged areas would have worse baseline physical function and increased fall risk. **Methods:** This a secondary analysis of baseline data from the Mobility and Voiding Exercises in Older Women with Urinary Incontinence (MoVEonUP) clinical trial, a single-site, randomized controlled trial evaluating a home-based, multi-component intervention aimed at reducing falls and UUI among community-dwelling women aged ≥ 70 with UUI. Demographic data and baseline fall data were collected at study enrollment. Neighborhood-level socioeconomic disadvantage was defined by the Neighborhood Atlas Area Deprivation Index (ADI). Validated questionnaires collected at enrollment assessed baseline physical function. We assessed physical function(primary outcome) and falls risk

in quartiles of ADI exposure using stratified analysis. **Results:** ADI was calculated for 316/320 patients. Higher quartile ADIs had higher proportion of Black participants (p<0.001) and participants with lower levels of educational attainment (p<0.001). There was no difference in baseline falls (p=0.38) or injurious falls (p=0.18) by ADI quartile. Higher ADI was correlated with worsening physical function testing (Table). Participants with ADI >85th percentile had worse Timed Up and Go (p= 0.001), higher Fall Efficacy Scale (p=0.01), lower Late Life Disability Index (p=0.03) and lower Short Physical Performance Battery Test (p=0.004) scores. **Conclusions:** Among older women with UUI, higher ADI was correlated with worse performance on physical function tests and higher concern for falling, indicating that neighborhood disadvantage may contribute to disparities in physical function and fall risk. Future work should identify barriers to physical activity in older women in disadvantaged neighborhoods and develop interventions to overcome such barriers.

Correlation of ADI with physical activity instruments

Validated instrument	ADI Correlation Coefficient	P-value
Timed Get Up and Go (TUG)	0.310	<0.001
Falls Efficacy Scale (FES)	0.199	<0.001
Activities Balance Specific Scale (ABS)	-0.187	0.001
Late-Life Disability Index (LLDI) short form	-0.184	0.001
Short Physical Performance Battery Test (SPPB)	-0.335	<0.001

A202

The effects of exercise on intrinsic capacity after hip fracture:

A systematic review and meta-analysis of the locomotion domain

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Background: Hip fractures can result in a sudden decline in intrinsic capacity (IC) in older adults. Structured exercise programs can improve multiple IC domains. However, no study has evaluated their impact post hip fracture using the World Health Organization (WHO) Integrated care for older people approach (ICOPE) framework. This systematic review and meta-analysis aims to summarize the effect of exercise interventions in older adults following a hip fracture across the locomotion domain.

Methods: We conducted a systematic search of EMBASE, MEDLINE, CINAHL, and CENTRAL. Eligible studies included: (i) randomized controlled trial design, (ii) older adults aged 60 years or older who experienced a hip fracture, (iii) an exercise intervention, and (iv) outcomes related to locomotor capacity. Risk of bias was assessed using the Cochrane Risk of Bias 2 (RoB-2) tool, and the certainty of evidence was evaluated using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach.

Results: Of 5053 records screened, 20 randomized controlled trials (N=2471 participants) assessed the effect of exercise on locomotor capacity. Exercise interventions after hip fracture varied in frequency (2-7 sessions per week), type (resistance, balance, endurance, or multicomponent programs), and duration (3 weeks–12 months). Across 6 studies (n=398 participants), we found exercise may reduce Timed Up and Go (TUG) time after hip fracture; the mean difference was –3.39 seconds (95% confidence interval [CI] –3.77 to –3.01; low-certainty evidence) and exceeded the minimal clinically important difference. Across 4 studies (n= 244 participants), we found exercise may improve gait speed after hip fracture; the mean difference was +0.03 meters per second (95% CI 0.02 to 0.04; low-certainty evidence).

Conclusions: Structured exercise programs after hip fracture may have a positive effect on locomotor capacity recovery. More trials are needed to establish optimal exercise types, frequency, and duration. The ICOPE framework could be integrated as part of post-fracture rehabilitation.

A203

Defining the Value Case for Caregiver Support in Hospitals

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Background:

Much of the research on US family caregivers to date has focused on caregiving prevalence, caregiver well-being, and economic impact (1). However, while providers are in the best position to address caregiver burdens, there is less research and attention on the benefits to hospitals for providing meaningful caregiver support. This project accumulated the existing evidence that may motivate health care leaders into action.

Methods:

The authors conducted a literature review using the PubMed database and grey literature. Search terms focused on cost and quality issues that align with hospital business objectives, such as “readmission,” and “cost,” and pre-2016 articles were excluded. Additional articles were identified using the PubMed features “similar articles” and “cited by.”

Results:

A total of 43 articles were identified in the review. Sufficient evidence was found for an association between caregiver distress and increases in the patient’s: emergency department and hospital utilization; long-term facility placement; and mortality. One study demonstrated that caregiver depressive symptoms, sadness, and fatigue were significantly associated with an increase in the patient’s Medicare expenditures (2). There is also evidence that hospital-based caregiver psychosocial support interventions can lead to reductions in care recipient total hospital utilization and spending (3).

Conclusions:

Evidence exists that hospitals and other health care organizations can reap business and financial benefits from providing psychosocial support for the caregivers of their patients. To strengthen the value case, more research on the association between caregiver interventions and patient outcomes that impact publicly reported hospital quality measures is still needed.

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A204

Patient Perceptions of Medicare Annual Wellness Visits: Findings from a Pilot Survey

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Background: Medicare Annual Wellness Visits (AWVs) were introduced in 2011 to encourage the adoption of preventive health services by Medicare enrollees. Research on patient satisfaction with AWVs is limited. Jefferson Health is a participant in the John A. Hartford Foundation and Institute for Healthcare Improvement’s Age-Friendly Health Systems Initiative, and its Center for Healthy Aging (CHA) has embarked on an Age-Friendly redesign of its Medicare AWVs. The purpose of this study was to obtain baseline data on Medicare patients’ experience and satisfaction with Medicare AWVs in a Jefferson Health geriatrics practice.

Methods: This cross-sectional survey study took place at Jefferson Health’s CHA, a geriatrics practice with 2,000 patients located in downtown Philadelphia. Eligible survey participants were CHA patients with Medicare. An eight-item survey was developed based on a comprehensive literature review. Survey items assessed patient familiarity with the Medicare AWV, the importance of the AWV provider being a physician, and their satisfaction with the length of the visit, the information received, and the issues discussed during the visit. Patients were also asked if they made changes or followed suggestions based on the AWV, and their overall satisfaction with the AWV. The survey was distributed to eligible patients via the Epic MyChart messaging system in July 2025. Descriptive analyses were performed on the survey data.

Results: 467 patients (23.4%) completed the survey. Seventy-two percent were familiar with Medicare AWVs, and 65% had completed one. Of those who had completed an AWV, 68% said it was important or very important that the provider be a physician. The majority of participants were satisfied/very satisfied with visit length (70%), information provided (73%), and issues discussed (76%). Sixty percent reported making changes or following suggestions based on discussion with the AWV provider. Overall, 74% were satisfied/very satisfied with the AWV.

Conclusions: In this survey of patients in a geriatrics practice, baseline satisfaction with Medicare AWVs was high. The survey response rate may limit the representativeness of responses. A follow-up survey will be conducted in Summer 2026 to assess patient attitudes and satisfaction after the implementation of Age-Friendly Medicare AWVs.

A205

Loneliness and Rights Violations Among Elders: A Mixed-Methods Cross-Sectional Study in Kolkata, India

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Background

Rapid urbanization and changing family dynamics in India have increased the psychosocial vulnerabilities of elders. Despite existing legal protections, many elders continue to experience isolation, emotional neglect and violations of basic rights. This study examines the extent of loneliness and rights infringements among community-dwelling elders in an urban setting in Kolkata.

Study Setup (Methods)

A mixed-methods cross-sectional study was conducted among 326 adults aged 60-94years. Quantitative data were collected using a structured socio-demographic questionnaire and the UCLA Loneliness Scale (short form). Qualitative insights were generated through 30 in-depth interviews and field observations. Descriptive statistics and thematic analysis were applied to interpret findings.

Results

A significant majority (80%) reported frequent loneliness, while 66% had no regular visitors. Emotional distress was evident with 43% acknowledging episodes of crying due to perceived neglect. Rights violations were notable: 17% experienced verbal abuse, 26% reported financial exploitation, 38% faced inadequate access to medical care, and 29% described abandonment by family members. Women-particularly widows - were disproportionately affected, exhibiting higher levels of dependence and reduced legal awareness.

Discussion

The findings revealed a critical burden of social isolation and rights violations among elders in an urban Indian community. Despite living in a metropolitan environment many elders remain vulnerable to emotional abandonment and systemic neglect. Strengthened community engagement, legal literacy, and improved enforcement of elder-protective policies are essential to promote dignity, autonomy, and rights-based care for India’s growing aging population.

A206

Older Adult Perceptions of Artificial Intelligence (AI) Incorporation Within Their Healthcare

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Background

AI has been incorporated into many facets of our lives. Data has shown mixed levels of comfort with use of AI in the daily lives of older adults¹ and mixed levels of AI literacy² in this population, but little is known about AI in older adult healthcare. The aim of this study was to explore older adult perceptions of AI incorporation into their healthcare.

Methods

A five-question survey was developed, focusing on AI incorporation in older adult healthcare. Inclusion criteria were adults aged 50 or older. Data was collected during the month of November 2025. Study procedures were approved by the University of Kansas Medical Center (KUMC) Institutional Review Board and the survey was distributed through the Greyhawk registry at KUMC.

Results

The survey was sent to 505 adults aged 50 or older with 340 responding (67%). Analysis showed 22% (N = 74) of respondents were aware of healthcare scenarios where AI was being used in their care while 78% (N = 266) were not. 63% (N = 214) would prefer an informed consent process and an educational session prior to the use of AI in their healthcare. 42% (N=143) were unsure how AI could improve their overall healthcare experience. 61% (N=208) were unsure how AI could help improve their daily life with only 3.8% (N=13) reporting it could help reduce loneliness through digital companionship.

Conclusions

Our study shows that older adults have mixed feelings about the incorporation of AI into their daily lives, as previously stated in the literature. Furthermore, older adults are unsure how AI can improve their healthcare experience, but want to be informed about it's use and be educated about it. Notably, while 1 in 3 adults aged 50-80 report feeling isolated³, digital companionship via AI was not selected by this cohort for daily life improvement.

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A207

Patient Portal Use and Preferences in Dementia Care: Perspectives from Older Adults and Their Care Partners

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BACKGROUND: The patient portal is a critical tool for managing health information and facilitating communication among patients, families, and healthcare providers. However, older adults with dementia typically exhibit lower levels of portal engagement compared to

those without dementia. This study explored patient portal preferences among older adults with dementia and their family care partners.

METHODS: We conducted semi-structured interviews with 15 dementia patient-care partner dyads between August 2024 and March 2025. Adults aged ≥65 years, diagnosed with dementia, and identified from an ongoing trial to improve timely detection of cognitive impairment in primary care were eligible to participate, along with their family care partners. Interviews included open-ended questions about communication preferences and patient portal use. Dyads without portal access were also asked about barriers and facilitators to obtaining access. Interviews were conducted in English and Spanish via Microsoft Teams, transcribed, and analyzed using a rapid qualitative analysis approach.

RESULTS: Sixty percent (N = 9) of recruited dyads had patient and/or proxy access to the patient portal. Among these, portal use was primarily for scheduling appointments and viewing lab results, with limited secure messaging. Care partners valued convenience but reported challenges interpreting medical terminology and occasional technical issues. Dyads without portal access cited barriers including limited technology (e.g., lack of computer, reliance on small screens), digital literacy challenges, and competing caregiving demands. These participants often relied on paper-based systems and expressed interest in future portal use if support was available.

CONCLUSIONS: Dementia introduces unique challenges to patient portal use for patients and family members. Health systems can improve engagement by addressing barriers and tailoring portal features to meet the needs of older adults with dementia and their care partners. Strategies may include simplifying navigation, offering caregiver-friendly interfaces, and ensuring access to training and technical assistance to overcome digital literacy and technology limitations.

A208 Encore Presentation

Impact of Awareness of Osteoporosis and BMD Testing on Osteoporosis Medication Use in Older Men and Women with Osteoporosis

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Background

Research has shown that use of evidence-based osteoporosis treatment can prevent up to 32% of bone fractures. However, osteoporosis has long been seen as a women's disease due to the huge difference in the recorded prevalence of osteoporosis between men and women. Therefore, men and their physicians tend to lack awareness of osteoporosis and underutilize evidence-based osteoporosis treatment.

Objectives

To assess the impact of awareness of osteoporosis and bone mineral density (BMD) on osteoporosis medication use among older men and women with osteoporosis.

Methods

A pooled cross-sectional study using 2016-2018 Medicare Current Beneficiary Survey (MCBS) data linked with Medicare claims. The study sample included Medicare beneficiaries aged 65 years and older with evidence of osteoporosis (from claims or self-report) living in the community. Prescription medications used to treat osteoporosis included bisphosphonate, calcitonin, parathyroid hormone analog, selective estrogen receptor modulator, and RANKL inhibitor. Awareness of osteoporosis and BMD testing was captured in survey responses. Descriptive analyses on the characteristics of the sample and awareness of osteoporosis and BMD testing were conducted using chi-square test for categorical variables and then two multivariable logistic regressions with full sample weights and replicate weights using the balanced repeated replication method for variance estimation to estimate the impact of awareness of osteoporosis and BMD testing on osteoporosis medication use in men and women while adjusting for the covariates.

Results

The study sample comprised 866 male and 6,379 female Medicare beneficiaries with evidence of osteoporosis. Prevalence of osteoporosis medication use in men was substantially lower than that for women. In multivariable logistic regressions, women with awareness of osteoporosis and BMD testing were more likely to use any osteoporosis medications while adjusting for the covariates whereas no significant association between awareness of osteoporosis and BMD testing and osteoporosis medication use was found in men.

Conclusions

Older men are significantly undertreated for osteoporosis compared to older women. However, awareness of osteoporosis and BMD testing was associated with more osteoporosis medication use only in older women. Further research on larger samples is warranted.

A209

Hospitals' Age-Friendly Health Systems recognition and postoperative outcomes following hip fracture surgery

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BACKGROUND: Hip fractures among older adults present complex clinical challenges that extend far beyond surgical repair. Age-Friendly Health Systems (AFHS) recognition—a geriatric care initiative launched in 2019 to advance evidence-based, interdisciplinary care—offers a promising pathway to better hip-fracture care. However, the national impact of this initiative on postoperative outcomes among older adults with hip fracture remains largely unknown.

METHODS: Using the 2021 Medicare fee-for-service data, we conducted a cross-sectional study comparing postoperative outcomes between older adults with hip fracture treated at acute care hospitals with vs. without AFHS recognition. We identified patients aged 65 years and older who underwent hip fracture surgeries based on relevant Current Procedural Terminology codes. We determined AFHS recognition status of acute care hospitals using the AFHS database. We fitted a multivariable linear regression model to compare (1) 30-day postoperative mortality (death during hospital admission or within 30 days of the procedure) and (2) 30-day hospital readmission rate between hospitals with vs. without AFHS recognition, adjusting for patient characteristics.

RESULTS: Our study included 27,201 observations (across 2,764 hospitals), with 1,964 (7.2%) occurring in 141 hospitals with AFHS recognition. We found no evidence of difference between hospitals with vs. without AFHS recognition in 30-day postoperative mortality (adjusted rate, 7.1% vs. 7.5%; adjusted difference, -0.3 percentage points; 95% confidence interval, -1.4 to +0.8; P-value = 0.57) or 30-day readmission rate (adjusted rate, 9.0% vs. 9.9%; adjusted difference, -0.9 percentage points; 95% confidence interval, -2.5 to +0.6; P-value = 0.23).

CONCLUSION: While we found no evidence of statistically significant association between hospitals' AFHS recognition and hip fracture postoperative outcomes, the observed differences may have clinical relevance. Further multi-year, methodologically robust studies are needed to assess the national impact of the AFHS recognition initiative on outcomes among older adults with hip fracture and guide health policy, including CMS's Age-Friendly Hospital Measure beginning in 2025.

A210

Feasibility of Supplementing VA MOVE! with a Health Coach to Achieve Individually Directed Weight Management in Older Comorbid Adults with Obesity

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Background: To supplement the MOVE! program for older comorbid Veterans with obesity, we established the Optimal Health, Weight, and Lifestyle (OHWL) clinic to provide comprehensive assessment and address comorbidity, physical disability, and geriatric principle-guided weight-loss medication treatment. Participants agreed to work with a Health Coach to facilitate adherence to treatment plan goals and address program barriers.

Methods: We sought to track participation of OHWL patients who opted in to the Health Coach program and understand their experiences with MOVE! (a national weight management program). We reviewed notes summarizing discussions with Veterans to classify participants based on whether past experiences were negative, positive, or neutral. Additional data analyses are in progress linking weight loss and other outcomes with obesity medication use, coach recommendations, and goals met.

Results: To date, 58 Veterans from the OHWL clinic were referred to the Health Coach, of which 17 decided to participate (29%). Among participants (mean age 75, mean BMI 38), 10 have completed 6-month follow-up and 2 are in progress. Attrition reasons include medical (n=2), early completion (n=1), and early discontinuation (n=2). Almost half of the participants expressed negative experiences with MOVE! (n=8; 47%), with the remaining expressing positive (n=4; 24%) or neutral experiences (n=5; 29%). A total of 7 participants discontinued MOVE! (41%), with the remaining completing group or individual programs (n=6; 35%), lifestyle coaching alone (n=2; 12%), or medication management and lifestyle coaching (n=2; 12%). Reported negative experiences related to perceived lack of value or redundancy in the program and difficulty in following recommendations.

Conclusions: We found that an extension of the OHWL clinic that includes the addition of a Health Coach to facilitate Veteran goal achievement is feasible and we are conducting an effectiveness evaluation to understand impact on weight loss and other outcomes. However, in the process of enrolling Veterans we found that the program must address negative patient-reported experiences of recruited Veterans with other weight management programs.

A211

Clinical Features of Opioid Use Disorder in Older Adults Experiencing Homelessness: Pain, Cognition, and Missed Opportunities

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Background: Older adults (OA) with lived experience of homelessness (LEH) represent a growing and medically complex population with elevated risk for opioid use disorder (OUD). Limited evidence exists to guide geriatric care for OA-LEH with OUD, particularly in areas of pain management and cognitive screening. This study describes the prevalence and associated clinical characteristics of OUD among OA-LEH to inform geriatric assessment and treatment planning in community-based settings.

Methods: We conducted a secondary analysis of electronic health record data from a community medical program serving OA-LEH aged ≥50 years in New York City. Demographics, OUD diagnoses, and available pain and cognitive screening results (PEG and Mini-Cog) were summarized.

Results: Among 253 OA-LEH, 12% (n=31; age range 50-81; 5 received opioid agonist therapy) had been diagnosed with OUD. Compared to persons without OUD, individuals with OUD were more often younger and female, and Black/African America – a finding that is at odds with literature about OUD racial trends in the general population. Pain assessments (n=14) indicated frequent moderate-to-severe pain, while cognitive assessments (n=18) showed low rates of clinically significant impairment among OA-LEH with OUD.

Conclusion: A subset of OA-LEH with OUD demonstrate substantial pain burden but relatively preserved cognition. This profile suggests distinct care needs, including routine assessments for untreated pain, screening for cognitive impairment, and attention to sex-specific and age-related patterns in OUD. Findings present an opportunity to consider potential care gaps among Black/African American OA-LEH that might be driving opioid misuse and pain levels in this cohort, including infrequent pain screenings and implicit and explicit biases against agonist therapy. Clinicians serving community and street-medicine populations may benefit from training that integrates pain management, cognitive assessment, and OUD treatment to engage OA-LEH. Results underscore the urgent need for geriatric-informed models of care to equitably serve this population.

A212

Cognitive Flexibility and Trust as Determinants of Telehealth Engagement Among Low-Income Older Adults in Medicaid-Funded Assisted Living Facilities: A Mixed-Methods Study

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Background: Inequitable telehealth expansion has left many low-income older adults without meaningful access, contributing to gaps in care. Residents of Medicaid-funded assisted living facilities (M-ALFs) are uniquely vulnerable: many have multimorbidity, limited digital exposure, cognitive impairment, and inconsistent support in setting up virtual encounters. Understanding how low-income older adults experience telehealth is critical for improving clinical outcomes. This mixed-methods study examines telehealth acceptance among low-income older adults in urban M-ALFs.

Methods: Forty-five older adults residing in three M-ALFs completed the Telehealth Acceptance Questionnaire (TAQ) and participated in semi-structured interviews about their experiences using telehealth. Quantitative TAQ scores were categorized as weak, moderate, or strong acceptance. Interviews were coded using conventional content analysis. Quantitative and qualitative results were combined using a frequency table to connect TAQ scores with qualitative code clusters to examine how experiential factors shape telehealth attitudes.

Results: Participants (17=Black, 3=Asian, 9=Latinx, and 9=White), varied in telehealth acceptance: 15 reported weak acceptance, 16 moderate acceptance, and 14 strong acceptance. Four qualitative themes were identified. Mixed-methods analysis showed that individuals with low TAQ scores viewed telehealth as a last resort when in-person care was unavailable, whereas participants with moderate or strong acceptance described a wider range of potential uses for telehealth, reflecting higher cognitive flexibility. While all participants described some concerns about building trust with health-care providers, those with lower telehealth acceptance feared clinicians would deliberately mislead patients.

Conclusion: Cognitive flexibility and trust appear to be clinically meaningful predictors of telehealth acceptance in low-income older adults. We make recommendations for clinicians to enhance trust and assess cognitive flexibility. Interventions that scaffold imagination, as well as those that amplify provider emotional presence, may enhance telehealth acceptance among low-income older adults.

A213

Palliative Care Consultations Among Hospitalized Latino Patients with Dementia: A Propensity Score Approach

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Background: Dementia prevalence is high among Latino older adults. Medical treatments offered to people living with dementia (PLWD) may misalign with their goals, reduce quality of life, and prolong suffering. Palliative care can help PLWD make informed decisions by aligning health care with their goals. However, palliative care disparities exist among Latino older adults and PLWD in general. We created matched cohorts of hospitalized Latino PLWD who received inpatient palliative care vs. those who did not and compared dementia-specific quality of care outcomes.

Methods: Using electronic health records, we identified hospitalized Latino PLWD in 2019 from a single New York City health system and collected the following outcomes through 2022: 1) subsequent hospitalizations, 2) antibiotic use during hospitalization, and 3) infection diagnosis (e.g., aspiration pneumonia). Using propensity score matching (on sex, age, marital status, and country of origin), we compared these outcomes in those who did vs. did not receive a palliative care consult during their index hospitalization.

Results: The sample included 1314 Latino PLWD (295 exposed; 1019 unexposed). They were mostly female (61%), unmarried (27%), and from the Caribbean (72%). Mean age was 80. Latino PLWD who had received a palliative care consult in their first index hospitalization had 5 hospitalizations on average compared to 3 among matched controls that did not receive a palliative care consult ($p<0.01$). They received more antibiotics compared to those without palliative care (91% vs. 72%, respectively; $p<0.01$) and had higher prevalence of infection diagnosis (64% vs. 41%, respectively; $p<0.01$).

Conclusions: Latino PLWD who received palliative care consults had more hospitalizations, higher antibiotic use and prevalence of infections. These findings are not a causal relationship and may indicate that palliative care consults are occurring later in the dementia disease trajectory when there are high-acuity situations. The integration of palliative care consults in outpatient settings may be called to help clarify goals of care after hospitalization and help address these issues.

A214

Exploring Hospice Care Outcomes for People Living with Advanced Dementia

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Background: Hospice care can improve care for people living with advanced dementia and their families resulting in fewer hospitalizations and improved symptom management. However, time spent in hospice care and timely referrals for hospice care can vary widely across clinical care settings. Identifying factors that may influence hospice referral is important. We aimed to outline the experiences of people in our community practice enrolled with hospice for a primary qualifying diagnosis of dementia and compare factors that influence live graduation.

Methods: We conducted a retrospective study of people age 65 and older in our community practice who were enrolled in hospice between June 2020-June 2022 with a primary hospice qualifying diagnosis of dementia. We compared demographic, clinical and social determinant of health factors between those who were enrolled to end of life and those who graduated live from hospice care. Associations were examined using Kruskal-Wallis and Chi-Square tests.

Results: Our study population included 124 people with a mean age of 87.1 years of whom there were 83 females (66.9%) and 77 (62.1%) had a palliative performance scale of less than 40% at time of enrollment. Most were living in care settings (106, 85.5%) with only 18 (14.5%) living at home. The majority (106, 85.5%) were enrolled in hospice care to end of life. Mean time spent in hospice care was 91.9 days to end of life. There were 18 live graduates (14.5%) who spent a mean of 155.7 days on hospice and 7 of these (38.9%) lived to one year post graduation. Live graduates were more likely to report social isolation concerns compared to those enrolled in hospice to end of life ($p=0.02$).

Conclusions: In our community practice, the overall time spent in hospice care for people enrolled for a primary qualifying diagnosis of dementia was short, and below the 6-month Medicare eligibility benefit period. Social isolation concerns were more common among hospice live graduates. Social assessments should be incorporated in discussions around end-of-life care.

A215

Evaluating Multilevel Factors Associated with Comprehensive Dementia Care in Primary Care

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Background

Comprehensive dementia care is essential to improving quality of care and outcomes. Primary care provides most dementia care but faces challenges. Our study examined dementia care practices and associations of individual, clinic, and organizational factors with comprehensive dementia care in primary care.

Methods

We conducted a cross-sectional electronic survey of dementia care, e-mailing 587 primary care providers and interdisciplinary staff (nurses, medical assistants, medical office assistants, care managers, social workers) from 29 community-based clinics of a large health system. Participants were divided into tertiles of comprehensive dementia care (low, medium and high) based on routinely addressing 8 domains of dementia care (cognition, mood, function, safety, caregiver, medications, advance care planning and dementia stage). We used chi-square tests to evaluate associations of care practices, attitudes, individual and clinic demographics and organizational climate with comprehensiveness of care.

Results

The 193 respondents (33%) represented all clinics. Care domains least addressed were dementia staging (24%), caregiver and safety assessments (45% and 47% respectively). 31% ($n=59$) reported routinely addressing 0-3 domains of comprehensive dementia care (low tertile), 41% ($n=79$) 4-6 domains (medium) and 28% ($n=55$) 7-8 domains (high). The high tertile was most likely to engage in dementia care planning (76%) vs 35% and 25% in medium and low, use behavioral/lifestyle interventions (91% vs 71% and 52%) and provide caregiver education (91% vs 63% and 39%); they were also most likely to engage in care coordination and community service referrals (all p 's < 0.001). Respondents with formal training in dementia were more likely to provide comprehensive care (45% of high tertile vs 14% and 20% in medium and low, $p=0.001$). Clinic demographics and organizational climate measures were not statistically significant.

Conclusions

Nearly a third of primary care providers and staff report routinely addressing most domains of comprehensive dementia care. Specific care practices and dementia training were associated with more comprehensive care. Results can guide interventions to support comprehensive dementia care including Medicare cognitive assessment and care planning in primary care.

A216

Primary Care and Early Dementia Diagnosis: Evaluating Multilevel Factors Associated with Practices and Attitudes

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Background

Early dementia diagnosis helps optimize treatment, care planning and support. Delayed diagnoses are common, including in primary care where dementia is most often detected. We examined whether primary care practices were making or willing to make early dementia diagnoses and associated individual, clinic, and organizational factors.

Methods

We conducted a cross-sectional electronic survey of dementia care among 587 primary care providers and interdisciplinary staff (nurses, medical assistants, medical office assistants, care managers, social workers) from 29 community-based clinics of a large health system. Respondents were categorized as (1) routinely making early diagnoses in their practice (2) interested/willing or (3) not interested in making early diagnoses. We examined bivariate associations of self-reported care practices, attitudes, individual and clinic demographics, and organizational climate with early diagnosis practices using chi-square tests.

Results

The 193 respondents (33% response rate) represented all clinics. 55% ($n=106$) reported routinely making early diagnoses, 32% ($n=61$) were interested/willing and 14% ($n=26$) were not interested in early diagnoses. Across all groups, routine assessment of cognition and mood was similar (77%). Functional assessment was highest in the early diagnosis group (66% vs 41% of interested and 54% not interested, $p=0.007$). Routine completion of all 3 assessments (cognition, mood, and function) followed a similar respective pattern (57% vs 23% and 35%, $p=0.001$). Attitudes toward early diagnosis and dementia care were associated with early diagnosis practices. Those making early diagnoses were most likely to rate early diagnosis, medications for dementia or behavioral symptoms, behavioral/lifestyle interventions, dementia care planning and caregiver/patient education as extremely important (all p 's < 0.05). Individual and clinic demographics and organizational climate measures were not statistically significant.

Conclusions

Most primary care providers and interdisciplinary staff feel they are making early dementia diagnoses or are interested in doing so. Supporting routine functional assessments and improving knowledge on benefits of dementia diagnosis and care are potential strategies to improve early diagnosis in primary care.

A217

Silver diamine fluoride application for root caries among older adults living with disabilities in dental provider shortage area: A Markov simulation study

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Background: Root caries affect oral health, particularly among the older adults living with disabilities with exposed root surfaces. Silver diamine fluoride (SDF) application that was approved by the U.S. FDA in 2014 has shown effectiveness in preventing and arresting root caries. This study aimed to evaluate the cost-effectiveness of SDF application for preventing and arresting root caries within context of dental provider shortage area.

Methods: A Markov simulation model was adopted from a health system (Nevada Medicaid) perspective. A 60-year-old subject with 23 teeth was simulated for 19 years. Twice a year application of 38% SDF on teeth was compared with no preventive intervention in terms of effectiveness and cost. Tooth years free of root caries were set as the effect. Transition probabilities were estimated from the data of a health system-based cohort and published studies, and costs were based on Nevada Medicaid and University of Nevada, Las Vegas (UNLV) Dental Practice Fee Schedules in 2024. The incremental cost-effectiveness ratio (ICER) was calculated to evaluate cost-effectiveness. Probabilistic sensitivity analyses were performed to evaluate the influence of data uncertainty. Willingness to pay threshold is \$50,000.

Results: SDF application was more effective (with a difference of 0.88 root caries-free tooth years) but also more costly (with a difference of \$6,477). The ICER was \$7,333 per root caries-free tooth year gained. In the probabilistic sensitivity analysis, SDF application was cost-effective when SDF application annual cost ranges from \$34 (ICER \$6,487) to \$60 (ICER \$8,080).

Conclusions: Semi-annual SDF application was cost-effective for preventing and arresting root caries under Medicaid in the State of Nevada where is statewide dental provider shortage area, particularly, Medicaid-accepting providers shortage. Extending CDT D1354 code extension to medical professional CPT Category I in order to promote SDF application rather than tooth extraction among Medicaid beneficiaries.

A218

When Survival Outpaces the System: Fragmented Care After Aortic Dissection Repair

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Background:

Transitions of care following high-risk vascular surgery, including repair of thoracoabdominal aortic dissection and ruptured abdominal aortic aneurysm (AAA), are among the most vulnerable points in healthcare delivery. Patients with multimorbidity, psychiatric illness, and social instability face increased risk of nonadherence and loss to follow-up. This case illustrates how geriatric and systems-based principles apply in a younger, physiologically frail patient whose recovery outpaced the healthcare system's ability to maintain cohesive care.

Methods:

A case-based qualitative analysis was conducted on a 61-year-old male following endovascular and open repair for thoracoabdominal aortic dissection and ruptured AAA. Data were obtained through chart review, direct patient contact, and multidisciplinary discussion across two health systems in different cities. Factors assessed included continuity barriers, psychosocial determinants, medication adherence, and impact of care coordination.

Results:

After extensive vascular surgery at a tertiary center, the patient, recently homeless and living in a rehabilitation facility in another city, presented to a different outpatient clinic seeking guidance on where to continue care. Comorbidities included chronic kidney disease IIIb, COPD, hypertension, schizophrenia, and stimulant use disorder. He was medically stable but lacked clear post-surgical ownership or follow-up planning. Barriers included incompatible records, cross-system accountability gaps, limited transportation, reduced health literacy, and social isolation. Through medication reconciliation, inter-system communication, and social work involvement, continuity was re-established, supporting anticoagulation adherence, psychiatric stability, and specialty follow-up. The patient identified as a middle-aged Black male with significant social and functional vulnerabilities

Conclusions:

This case highlights systemic challenges of care continuity for socially marginalized adults following complex surgery. Despite successful operative management of a high-mortality condition, long-term survival remained threatened by fragmented systems and structural inequities. Applying geriatric coordination frameworks to younger, socially and functionally frail adults is essential. Cross-system transition protocols and integrated communication channels may reduce post-surgical abandonment and improve survivorship.

A219

Interprofessional Primary Care Team Perspectives on Addressing Caregiver Strain of Older Adults with Dementia

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Background: Informal caregivers of people with dementia provided ~19.2 billion hours of unpaid help in 2024¹, enabling older adults with dementia to age in place but often leading to caregiver strain. Since family caregivers often accompany patients with dementia to primary care (PC) visits, identifying and addressing caregiver strain during PC visits may be critical steps to addressing caregiver overload, especially when PC settings provide medical care to more patients with dementia than any other setting².

Methods: To understand the feasibility of identifying/addressing caregiver strain in the PC setting, we conducted three discipline-specific asynchronous online focus groups (AOFGs) with prescribers (n = 5), nurses (n = 16), and social workers (n = 3) working in PC in New England. Each AOFG was conducted for ~1 month between January and April 2025, using Microsoft Teams. In each AOFG, the moderators inquired about caregiver strain as a problem, perceived needs related to addressing caregiver strain, and the feasibility of systematic screening for caregiver strain in PC. All chat messages were analyzed for intra- and inter-group themes.

Results: Themes were (1) all PC disciplines recognized caregiver strain during patient appointments. Nurses reported that patients' needs often exceeded their caregivers' capacity. (2) When addressing caregiver strain, nurses and prescribers (a) relied on social workers and/or directly providing informational resources and (b) reported not having accurate, easily accessible informational handouts (prescribers) and knowledge on service eligibility criteria and referral processes (nurses). (3) All disciplines voiced systematic screening for caregiver strain as a valuable option but questioned its feasibility due to high workloads.

Conclusions: Our study shows PC disciplines perceive a disparity between caregivers' needs and resources available in PC to address those needs. Feasible next steps include bolstering informational resources accessible to prescribers and nurses and caregiver strain screening via self-report.

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A220

Pharmacist-Led Televisits Identifies Medication Discrepancies and PIMs in Older Veterans

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Medication discrepancies and potentially inappropriate medications (PIMs) are common among older adults and contribute to adverse drug events (ADEs) and hospitalizations. Pharmacist-led televisits provides structured medication management offering opportunities to

improve medication use. Despite increasing use of virtual care, data on discrepancies and PIMs use during pharmacist-led televisits are limited.

We retrospectively reviewed 20 pharmacist-led televisits within a randomized trial evaluating video visits in older adults, included aged ≥ 65 , ≥ 5 daily medicines, and ≥ 2 chronic conditions. Pharmacists identified discrepancies and PIMs and sent recommendations to primary care providers. Discrepancies were extracted using a structured medication discrepancy tool and categorized as patient-level, system-level, or mixed-level. At the time of visit, the patient's active medication list served as the reference point against which discrepancies were identified. PIMs were identified by using existing criteria (i.e. AGS Beers, STOPP). ADEs were counted when patients experienced medication-related symptoms or when a new medication was added to address prior to ADE. We summarized the number and type of discrepancies and proportion of the top drug classes involved in PIMs.

Among 20 televisits, 82 medication issues were identified: 58 patient-level, 24 system-level, and 3 mixed-level. Patient-level discrepancies included 9 (15.5%) unintentional non-adherence, 28 (48.3%) intentional non-adherence, 18 (31.0%) omissions, and 3 (5.2%) ADEs. System-level discrepancies primarily included 17 (70.8%) expired prescriptions, 2 (8.3%) duplicate therapy, 2 (8.3%) unknown indications. Mixed-level included in each relevant category; numbers sum $>100\%$ because 3 discrepancies were classified in more than one category. There were 35 PIMs identified; most common drug classes were NSAIDs (9), proton pump inhibitors (6), and antidepressants (5).

High rates of discrepancies and PIMs identified during pharmacist-led televisits highlight the essential role of pharmacists in virtual medication management for older adults. Integrating pharmacists into telehealth workflow can improve detection of medication-related problems and support safer prescribing practices.

A221

Barriers and Facilitators of Deprescribing Conversations Among Black Older Adults in Low Socioeconomic Settings

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Background: There is a disproportionate chronic disease burden among older adults in racial/ethnic minority communities, especially those with lower socioeconomic status (SES). They also experience multiple chronic conditions, polypharmacy (concurrent use of 5 or more medications) and higher medication regimen complexity leading to poorer medication adherence, higher hospitalizations, inappropriate medication use and adverse drug events. A possible means of reducing polypharmacy and improving the quality of life for these minority older adults with low SES is deprescribing. However, for deprescribing to work, the patient needs to initiate the conversation with the provider. The objective of this study is to examine the perception of community dwelling Black older adults' regarding initiating deprescribing conversations with their providers.

Methods: We used face-to-face, individual interviews (n =12) and two focus groups (n=6 per group). Participants were community dwelling older adults (age >60) recruited from senior centers in predominantly Black neighborhoods. Focus groups and interviews were recorded and transcribed verbatim. We used a hybrid deductive-inductive analysis with Theoretical Domains Framework as the primary coding and interpretive framework, while our inductive process led to draw on cognitive load theory, complexity theory and Weick's sense-making theory to interpret the conversations.

Results: Our preliminary results indicate five main themes with regards to barriers to initiating deprescribing: 1) High polypharmacy and medication regimen complexity preventing the recall of medications and their functions 2) Low medication self-efficacy;

3) Normalization and social norms; 4) Resignation and acceptance of their medications; 4) Necessity concerns and 5) lack of awareness regarding the concept of deprescribing.

Conclusions: Digital tools that support medication tracking, memory and recall of medication and functions, and confidence in self-management can facilitate and enhance deprescribing provider discussions. Pharmacist support combined with clinician specialized in deprescribing training is crucial.

A222

Effectiveness of Long-Term Care Insurance Among Older Adults in China: Evidence From a Provincial Health Survey

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Background:

China's long-term care insurance (LTCI) aims to address rising care needs, yet its impact on healthcare utilization and financial burden remains unclear. We examined how LTCI participation affects outpatient and inpatient service use and expenditures, and whether effects differ by insurance enrollment and socioeconomic status.

Methods:

We used data from the 2023 Shandong Health Service Survey, a multistage stratified sample of adults aged ≥ 45 years (N=16,347). Outcomes included outpatient and inpatient utilization (binary) and out-of-pocket expenditures (log-transformed), plus annual household medical spending. The main exposure was LTCI participation. Heterogeneity was assessed using interaction terms for Urban Employee Basic Medical Insurance (UEBMI) and low-income status (<25 th percentile). Probit models were used for utilization and OLS for expenditures. Instrumental variable estimation using county-level LTCI participation addressed endogeneity. Models adjusted for socio-demographic, health, insurance, and behavioral covariates.

Results:

LTCI participation reduced outpatient utilization by 34.33% ($p<0.01$) in IV analyses and showed no significant effect on outpatient spending. In contrast, LTCI increased inpatient utilization by 53.08% ($p<0.01$) while reducing inpatient expenditures by 32.38% ($p<0.01$). Heterogeneity analyses showed larger financial protection effects among low-income adults, whereas reductions in inpatient spending were smaller for UEBMI enrollees.

Conclusions:

LTCI participation shifts service use toward inpatient care while substantially lowering associated financial burden. Increased inpatient utilization alongside reduced spending suggests improved access to necessary institutional care and enhanced risk protection. Heterogeneous effects across income and insurance groups highlight the need to refine LTCI benefit design to promote equity.

A223

Infidelity Delusion in Atypical Alzheimer's Disease: Diagnostic and Management Challenges

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Background:

A 72-year-old woman presented with an infidelity delusion and progressive cognitive decline accompanied by severe behavioral disturbances. Neurocognitive disorders in older adults often manifest with overlapping cognitive, psychiatric, and functional decline, complicating diagnosis and management. Behavioral symptoms such as hallucinations, delusions, and disinhibition increase caregiver burden and accelerate institutionalization. This case highlights diagnostic challenges and implications for care.

Methods:

A case report from a geriatrics clinic. A comprehensive geriatric assessment was performed, including ADLs/IADLs, neurocognitive testing (SLUMS, GDS, CAM), laboratory work-up, pTau-217/A β 42,

and skin biopsy for alpha-synucleinopathy. Imaging included MRI and FDG-PET. Collateral information was obtained from family.

Results:

The patient exhibited prominent infidelity delusion toward her spouse with progressive short-term memory loss since 2021. She developed disorientation, impaired executive function, obsessive behaviors, hallucinations, agitation, and sexual disinhibition. SLUMS score was 15/30, indicating executive and visuospatial deficits; GDS score 5/15. MRI showed mild small vessel disease. FDG-PET revealed hypometabolism in bilateral frontal, posterior parietal, and temporal lobes, especially in posterior parietal and posterior cingulate gyri—findings consistent with Alzheimer's disease but with atypical frontal involvement suggesting a behavioral variant. Alpha-synucleinopathy biopsy was negative, ruling out Lewy body dementia. Plasma pTau-217/Aβ42 ratio was positive, confirming atypical Alzheimer's pathology. Functionally, she needed help with medications, finances, and transportation but remained independent in basic ADLs. Management included donepezil and quetiapine, titrated to 450 mg/day for delusions and agitation.

Conclusions:

This case underscores the complexity of diagnosing dementia when behavioral and psychiatric symptoms predominate. The pTau-217/Aβ42 ratio was pivotal in confirming atypical Alzheimer's disease with atypical frontal features. Recognizing such presentations prevents misdiagnosis as primary psychiatric illness. Early diagnosis, multimodal therapy, and caregiver support are key to optimizing outcomes.

A224

Resource Utilization and Clinical Characteristics in Very Old Adults with ALS

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BACKGROUND: The impact of very advanced age on resource use and clinical management in amyotrophic lateral sclerosis (ALS) is not well understood. This study compared hospitalization rates, emergency department utilization, and clinical characteristics between old (60–74 years) and very old (75 years and older) veterans diagnosed with ALS.

METHODS: This is a retrospective cohort study that included veterans with ALS aged 60 years or older diagnosed between 2017 and 2025. The patients are enrolled at the ALS Center for Excellence Clinic at the South Texas Veterans Health Care System in San Antonio, TX. Patients were grouped as “old” (60–74 years) and “very old” (≥75 years). The primary outcome was resource utilization defined as number of hospitalizations and ED visits.

RESULTS: We enrolled 97 ALS patients, with 66% considered “old” (60–74 years, n=64) and 34% “very old” (≥75 years, n=33), respectively. The very old ALS group had a higher proportion of men (100% vs 85.9%, p=0.026) but similar disease severity (ALSFRS-R 20.39 vs 20.53, p=0.96). Hospice consultation was more frequent in the very old patients (45.5% vs 31.2%, p=0.25) but did not reach statistical significance. Old ALS patients had similar resource utilization compared to very old ALS patients regarding any hospitalization (30.3% vs 40.6%, p=0.38), mean hospitalizations (1.18 vs 0.83, p=0.45), any ED visit (42.4% vs 40.6%, p=1.00), and mean ED visits (2.42 vs 1.09, p=0.05).

CONCLUSIONS: Among older adults with ALS, being 75 years or older is not independently associated with increased acute care resources. These findings suggest that factors other than chronological age such as comorbidities and functional status over time, may better predict resource needs. Further studies should examine other types of support, such as home care needs or caregiver support.

A225

Missed Delirium in Older Adults With Hearing Loss: A Disability Justice Approach to Sensory-Inclusive Clinical Care.

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Delirium is a high-risk geriatric syndrome, yet its detection relies on verbal communication and behavioral observation, domains disproportionately affected by untreated hearing loss. Older adults with sensory disabilities, particularly racially and linguistically minoritized groups, are vulnerable to cognitive misclassification. This narrative review synthesizes evidence on how hearing loss contributes to missed delirium and applies a disability justice lens to identify structural and clinical contributors to inequitable assessment. We conducted a narrative review of peer-reviewed literature (2000–2025) in PubMed and Scopus using terms including “delirium,” “hearing loss,” “sensory impairment,” “communication barriers,” “geriatric assessment,” and “disability justice.” Included studies described hospitalized adults ≥65 years, assessed hearing, or reported delirium detection, diagnostic accuracy, or sensory accommodations. Data on clinical presentation, assessment tools, and interventions were extracted and synthesized thematically using a disability-informed framework. Preliminary synthesis across 67 studies indicates that hearing loss reduces delirium assessment accuracy, delays recognition, and increases misclassification. Mechanisms include misheard orientation questions, limited engagement during cognitive testing, ambient noise, absent amplification devices, and reliance on communication-heavy tools. Sensory-inclusive strategies, amplification devices, visual cues, multimodal orientation supports, and routine hearing screening, improved cognitive assessment fidelity and reduced diagnostic ambiguity. Hearing loss is an under-recognized social and sensory determinant of delirium misdiagnosis, disproportionately affecting marginalized older adults. A disability justice framework emphasizes that sensory accessibility is central to equitable geriatric care. Integrating accessibility strategies into acute care operationalizes an inclusive model of gerontology that improves cognitive outcomes and advances ethical care standards.

A226

Racial Differences in Dementia: Insights from the Memory Clinic Registry Project

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Alzheimer's disease is projected to affect 13 million Americans by 2050, with African Americans facing nearly twice the risk of White individuals. This disparity requires longitudinal data that captures cognitive aging across diverse populations. The Memory Clinic Registry follows individuals across the cognitive spectrum to support clinical trials and characterize clinical, functional, and psychosocial real-world outcomes.

Adults aged ≥18 are recruited during memory clinic visits and community outreach events. Annual assessments include cognitive testing (MMSE, MoCA, CDR), medical history, caregiver burden (ZBI), and depressive symptoms (GDS). Optional blood biomarkers and CSF collection are performed, with ApoE genotyping offered once. Descriptive analyses compared the mean scores of these assessments between African American and White participants.

The registry includes 546 participants: 20% African American, 78% White, and 2% Other. Our population has a mean age of 72 ± 12 years and is 62% female. Cognitive performance was similar across

racial groups on MMSE, MoCA, and CDR. However, psychosocial measures differed: White caregivers reported 18% higher overall caregiver burden, while African American caregivers experienced 7% greater financial strain. African American participants reported markedly higher depressive symptoms, with GDS scores 46% greater than those of White participants.

African Americans comprise 20% of our registry, which is higher than observed in national Alzheimer's registries (~5%), providing an opportunity to study racial differences in dementia-related outcomes. While cognitive performance did not differ across groups, disparities in depressive symptoms and caregiver burden highlight sociocultural and structural factors that shape the lived experience of dementia. Future research should focus on identifying the drivers of these differences and developing culturally informed interventions to support diverse patients and caregivers.

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A227

Assessing the Effectiveness of Reminiscence Therapy and Nutritional Support in Improving Psychological Well-Being and Quality of Life among Elderly Individuals with Dementia

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Background: Dementia is a progressive neurodegenerative disorder causing cognitive decline, behavioral changes, and reduced quality of life. Affected older adults often experience depression, anxiety, reduced appetite, and risk of malnutrition. Nonpharmacological interventions are important to improve psychological and functional outcomes. Reminiscence therapy uses photographs, music, life stories, and familiar objects to promote emotional expression, reduce depressive symptoms, and enhance social interaction. Nutritional support addresses appetite loss, weight loss, and deficiencies that worsen function and mood. Combining reminiscence therapy with individualized nutritional support may produce synergistic benefits.

Aim: To evaluate the effectiveness of reminiscence therapy combined with nutritional support in improving psychological well-being and quality of life in elderly persons with dementia.

Methods: A quantitative pretest-posttest design will recruit 100 residents aged above 60 and older with a clinical diagnosis of dementia from dementia-focused facilities using purposive sampling. Inclusion: diagnosis of dementia and ability to participate with guidance. Exclusion: severe psychiatric disorders unrelated to dementia, terminal illness, or medical instability. Measures: sociodemographic form, Mini-Mental State Examination (MMSE) for cognition, Mini Nutritional Assessment (MNA) for nutrition, WHO-5 for psychological well-being, and WHOQOL for quality of life.

Intervention: Individual reminiscence sessions (20-30 minutes), five times weekly for six weeks, using photographs, memory boxes, music, and life stories led by trained staff. Nutritional support includes MNA-guided assessment, individualized diet plans addressing calories and protein, texture modification for dysphagia, monitoring of appetite, weight and BMI, and supplements as needed, with dietitian and caregiver collaboration.

Data analysis: Descriptive statistics will summarize baseline data. Paired t tests will compare pre- and post-intervention scores. Pearson or Spearman correlation will examine relationships among cognition, nutrition, and well-being. Significance set at $p < 0.05$.

Expected outcomes: Improved psychological well-being, reduced depressive symptoms, better nutritional status and appetite, enhanced cognitive engagement, and increased overall quality of life.

A228

Cortical Inhibitory Tone Predicts Network Segregation in Advanced Aging

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Age-related reductions in GABAergic inhibition are linked to cortical dedifferentiation and diminished functional network specialization. However, the relationship between in vivo GABA, and network segregation in older adults remains unclear. We tested whether cortical inhibitory tone relates to network segregation and cortical thickness, and whether these associations differ from glutamate/glutamine (Glx) or N-acetylaspartate (Naa).

Older adults (N=86; mean age 88 ± 4.1 years; 63% women; 72% White, 18% Black) completed 3T MEGA-PRESS spectroscopy in medial frontal cortex, resting-state fMRI, and structural MRI. GABA+ spectra were processed using two independent Gannet pipelines (v3.3.1, v3.5.1). After outlier removal ($|z| > 3$), a quality-weighted composite inhibitory index (BestGABA_z) was created by combining raw and tissue-corrected values across versions. Network segregation for default-mode, frontoparietal, and association networks, including core-density hub metrics, was calculated. Cortical thickness was quantified globally and for each network. Analyses employed Pearson and partial correlations controlling for age, sex, and education.

BestGABA_z was positively associated with whole-brain cortical thickness ($r=0.34$, $p=0.01$), frontoparietal thickness ($r=0.34$, $p=0.01$), and frontoparietal core-density thickness ($r=0.30$, $p=0.01$). BestGABA_z was also associated with greater network segregation, especially within core-density hubs of default-mode and frontoparietal networks ($r=0.28-0.36$), though these did not survive false-discovery-rate correction. In contrast, Glx and Naa showed no associations with segregation or thickness.

Inhibitory tone, but not excitatory or metabolic markers, is selectively related to preserved cortical structure and functional network organization in advanced aging. These findings identify GABAergic mechanisms as a potential target for interventions aimed at maintaining network specialization and supporting healthy cognitive aging.

Table 1. Participant Characteristics

N	86
Age (mean $\pm$ SD)	88.0 ± 4.1 years
Sex (% women)	63%
Race/Ethnicity	72% White, 18% Black, 10% Other
Education (mean $\pm$ SD)	13.8 ± 2.4 years
MOCA (mean $\pm$ SD)	25 ± 1.7

A229

The Burden Before the Injury: Is Pre-Existing Depression a Hidden Driver of Resource Utilization in Geriatric Traumatic Brain Injury?

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Background: There is growing recognition that psychiatric comorbidities, like major depressive disorder (MDD), shape trauma outcomes, particularly among geriatric patients. Although literature on MDD after traumatic brain injury (TBI) exists, research examining pre-TBI MDD in the geriatric community remains limited. This study examined the impact of pre-existing MDD outcomes in geriatric TBI patients.

Methods: A retrospective chart review was conducted of geriatric patients (>65 years old) admitted to our Level I Trauma Center in 2023 and 2024. Patients were identified through the trauma registry, and

data was gathered from electronic medical records. Patients were stratified by documentation of pre-injury MDD and TBI severity. Severity was defined via Glasgow Coma Scale (GCS): mild (12–15), moderate (8–11), and severe (<8). Statistical analysis included Kruskal-Wallis Test and chi-squared test with $p < 0.05$ as threshold for significance.

Results: Of the 699 identified patients, 156 (22%) had a pre-injury MDD diagnosis. Overall, 597 patients sustained mild TBI, 42 moderate TBI, and 60 severe TBI. Among patients with moderate TBI, those with MDD had significantly longer ICU stays (6 vs 2 days; $p < 0.001$) and more ventilator days (2 vs 0 days; $p < 0.001$) compared with non-MDD patients. In the severe TBI subgroup, patients with MDD had increased ICU days (4.5 vs 3 days; $p < 0.001$) and ventilator days (6.5 vs 2 days; $p < 0.001$) compared to those without MDD.

Conclusions: Although mental health comorbidities are common in geriatric patients, this study confirms MDD does impact resource use in geriatric TBI. Methods of pre-TBI MDD diagnosis as well as integration of behavioral health recovery treatment should be examined. Future work should examine the broader impact of pre-injury MDD on outcomes in this vulnerable population.

A230

Mortality Trends Among Older Veterans With ALS

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BACKGROUND: Amyotrophic Lateral Sclerosis (ALS) is a progressing, incurable and debilitating disease. Older age has been linked with worse outcomes in ALS, but the size of this effect is unclear. We examined the association between age and mortality in a cohort of veterans with ALS.

METHODS: This is a retrospective cohort study that included veterans with ALS seen between 2017 and 2025 at a specialized ALS Center for Excellence Clinic at the South Texas Veterans Health Care System in San Antonio, TX. Patients were stratified according to age into two groups: younger (<65 years) and older (≥65 years). The primary outcome was mortality at 5 years from the time of ALS diagnosis.

RESULTS: Of the 128 patients with ALS, 46 (36%) were younger (<65 years old) and 82 (64%) were older (≥65 years old). Younger patients had a median survival of 2.81 years compared to 1.83 years for older patients (0.98-year difference). Functional status, respiratory support, and disease-modifying treatment use were comparable between groups. Mortality within 5 years of ALS diagnosis was 50.0% (23/46) in younger patients and 67.1% (55/82) in older patients (Odds Ratio 1.49 [95% CI: 0.92–2.43; $p = 0.32$]. However, older patients received hospice consultation significantly more often compared to younger veterans with ALS (39.0% vs 19.6%, $p = 0.039$).

CONCLUSIONS: Older age (≥65 years) ALS patients have similar mortality within 5 years of ALS diagnosis compared to younger ALS patients. These findings suggest that in addition to age, there are other important factors, such as hospice care, that may influence mortality among this high-risk group of patients.

A231

Health and Psychosocial Outcomes of Spousal Caregivers After an Older Adult Undergoes Surgery

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BACKGROUND: Older adults increasingly undergo major surgery and rely on spousal caregivers after surgery. We hypothesize that spousal caregivers of older adults who underwent surgery experience worse outcomes than those spouses who did not need to serve as caregivers after surgery.

METHODS: Using the Health and Retirement Study (HRS)-Medicare linked dataset (1993–2018), to identify 23,868 spouses of surgical patients. Postoperative spouse caregivers were compared with non-caregiver spouses across depressive symptoms, multimorbidity, self-rated health, pain, sensory impairments, Activities of Daily Living (ADLs)/ Instrumental Activities of Daily Living (IADLs), chronic conditions, health behaviors, and cognition using multivariable logistic regression.

RESULTS: A total of 23,868 spouses were identified (mean age 74 years; 60% female; 92% White). At baseline, 42% were presented with multimorbidity, 72% poor self-rated health, 74% pain, 66% history of falls, 71–85% sensory impairment and 83% depressive symptoms. After surgery, those spouses that are caregivers, as compared to those are not caregivers, had higher rates of depressive symptoms (27% vs. 15%, $p < 0.001$), multimorbidity (53% vs. 43%, $p = 0.032$), poor self-rated health (39% vs. 23%, $p < 0.001$), and significant pain (37% vs. 25%, $p = 0.002$).

DISCUSSION: Caregiving spouses of older adults who underwent surgery reported worse medical and psychosocial outcomes as compared to non-caregiving spouses. Despite preserved ADL independence, caregiver-spouses were consistently more vulnerable than non-caregiver spouses. Our finding highlights the importance of assessing caregiver capacity and caregiving-spousal intervention development in perioperative care.

A232

Anti-amyloid Therapy: Treatment and Discontinuation in a Community Memory Clinic

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Introduction

Lecanemab is a humanized monoclonal antibody that binds with high affinity to Aβ soluble protofibrils. Donanemab is a humanized monoclonal antibody that binds to established Aβ plaques. Both were approved by the FDA for treatment of mild cognitive impairment and mild dementia due to Alzheimer's disease; lecanemab in July 2023 and donanemab in July 2024. As disease-modifying therapy, lecanemab and donanemab have shown efficacy in slowing disease progression. The potential risk of amyloid related imaging abnormalities (ARIA) has made the medications controversial due to risk of patient harm.

Methods

This retrospective observational study was conducted at a specialty memory clinic in a community health system in Louisville, KY. The study aimed to determine the rate of patients discontinuing treatment with lecanemab or donanemab and to determine if ARIA was the reason treatment was discontinued. 258 patients who began treatment with lecanemab or donanemab between August 2023 and October 2025 were observed

Results

Of 204 patients who received lecanemab, 39 patients discontinued treatment. Although ARIA was observed in 47 of the 204 patients, ARIA led to discontinuation of lecanemab in only 13 cases.

26 additional patients discontinued lecanemab due to other causes, including other medical conditions and patient choice. Of 54 patients who had received donanemab, 9 patients discontinued treatment. Although ARIA was observed in 12 of the 54 patients, ARIA led to discontinuation of donanemab in 6 cases.

Conclusions

In this observational study, ARIA was not the only cause for patients to discontinue treatment with lecanemab or donanemab. In this study, patients were twice as likely to discontinue treatment with lecanemab due to other causes. Although the number of patients on donanemab was smaller, ARIA was the primary cause of discontinuation of donanemab.

Although ARIA is a serious potential side effect of anti-amyloid therapy, fear of ARIA shouldn't prevent clinicians from considering amyloid targeting therapy as a reasonable, effective therapy choice for treating early stage Alzheimer's disease.

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A233

From Beers Criteria to bedside: How do guidelines fare during acute care visits when prescribing or continuing psychotropic medications in older adults?

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Background: Despite Beers Criteria recommendations against their use by the American Geriatrics Society, psychotropic medications (antipsychotics and benzodiazepines) remain common first-line therapies for behavioral symptoms of dementia and delirium in emergency departments (ED), inpatient, and outpatient settings.

Methods: We conducted a retrospective single-center, cross-sectional study of older adults aged ≥ 55 years who received psychotropics in the ED and hospital at a large academic medical center in 2023. Data variables included demographics, history of neuropsychiatric disorders, home medications, psychotropics ordered (aripiprazole, clonazepam, diazepam, droperidol, haloperidol, lorazepam, midazolam, olanzapine, quetiapine, risperidone, ziprasidone), and number of medication administrations. Outcomes include clinical indications for administration (behavioral, procedures, seizures, alcohol withdrawal, other) and proportion of psychotropic orders which were new (not previously listed in home medications).

Results: Of 500 patients, the median age was 65 years old, 49% female, and 68% White. Most (88%, n=440) were admitted to the hospital. Approximately 35% (n=173) had a neurocognitive disorder, including dementia, 46% (n=228) had a primary psychiatric disorder, and 20% (n=99) had no neuropsychiatric history. There was a total of 811 psychotropic medication administrations. Half (51%, n=411) of these administrations were for managing behavioral symptoms. Home psychotropic medications (26.6%, n=133 people) included 265 prescriptions total and 51.3% (136 out of 265) were continued during the hospitalization. New prescriptions made up 80.4% (n=560/696). Patients averaged 1.4 [range 1-5] psychotropic orders per person.

Conclusion: This data suggests that acute behavioral symptoms are the driver for half of psychotropic drug administration in older patients presenting to EDs and hospitals. Additionally, home psychotropic medications are overwhelmingly continued in the hospital. These findings highlight the need for standardized and best practice approaches to managing acute neuropsychiatric symptoms in older patients and indicate an opportunity for deprescribing and medication stewardship.

A234

Supportive Therapy and Cognitive Function in Older Cancer Survivors

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Background: Older cancer survivors (OCS) are at higher risk for age- and cancer-related cognitive decline that affect daily functioning and cancer survival. However, interventions for improving OCS' cognition are scarce. We evaluated how supportive therapy (ST) grounded in Rogerian principles enhanced cognition through high-quality listening and empathy.

Methods: Secondary analysis of an RCT comparing ST to a CBT-based intervention. This analysis focused on the ST arm only. Women aged 65+ years, with breast cancer and undergoing systemic therapy, completed 10 weekly, 1-hour ST sessions via videoconference. Cognitive outcomes were assessed pre- and post-intervention using measures of subjective (Functional Assessment Cancer Therapy Cognitive Function [FACT-Cog]; Perceived Cognitive Impairment [PCI] and Abilities [PCA] domains) and objective cognition (Controlled Oral Word Association [COWA], Hopkins Verbal Learning Test Revised [HVL-T-R], and Brief Test of Adult Cognition by Telephone [BTACT]). We ran paired-samples t-tests or nonparametric tests, as appropriate, to test differences in cognitive outcomes. Alpha was set at 0.10.

Results: A total of 32 participants were included in the analysis (mean age=70.4 $\pm$ 4.7 years; advanced cancer, 46.9%; $\geq$ college education, 54.3%; racial or ethnic minority, 15.2%). Table 1 shows subjective and objective cognitive outcomes.

Conclusions: ST effectively improved subjective cognition, verbal fluency, executive function, and working memory but did not affect verbal memory in older adults with cancer. The findings suggest that integrating high-quality and empathy-based listening may enhance cognitive outcomes, emphasizing the importance of psychosocial support in survivorship care.

Effects of a ST intervention on the cognitive health of older adults with cancer

Cognitive outcome	Pre-intervention Mean (SD)	Post-intervention Mean (SD)	Test Statistic	P-value
FACT-Cog PCI	54.84 (12.38)	57.00 (11.28)	W=177.5	0.39
FACT-Cog PCA	19.31 (6.38)	20.63 (5.67)	W=118.5	0.09
COWA	35.72 (9.54)	38.50 (9.71)	t=-2.46	0.02
HVL-T-R Immediate	22.16 (5.10)	23.19 (5.37)	t=-1.18	0.25
HVL-T-R Delayed	7.97 (2.49)	7.69 (2.62)	t=0.78	0.44
BTACT	3.97 (1.45)	4.47 (1.57)	W=64.5	0.07

Note. t, paired samples t-test; W, Wilcoxon-signed rank test.

A235

Osteoporosis Screening in an Academic Primary Care Clinic

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Background: In 2002, the USPSTF recommended osteoporosis screening for all women 65 years or older, and for younger postmenopausal women with one or more risk factors for osteoporosis. Rates of osteoporosis screening remain low in the US, with estimates of around 50% of eligible patients being screened. Identifying and treating osteoporosis in primary care reduces fracture risk and associated mortality. In our study at an urban academic family practice housing geriatric medicine fellowship, we aimed to increase the rate of osteoporosis screening.

Methods: We used SlicerDicer software in the Epic EHR to identify clinic patients with female legal sex, age 65 or older, without a DEXA in the last 15 years. Registries of patients needing osteoporosis

screening were provided to the designated primary care providers (PCPs). Based on these registries, PCPs were asked to order DEXA scans for appropriate patients, and to communicate these orders with patients. To facilitate the intervention, our team shared osteoporosis educational materials and optimal DEXA ordering workflow strategies. Following a 5-week study period, the analysis was repeated.

Results: The percentage of patients who had a DEXA ordered increased from 49% (286/584) at study baseline to 60% (353/584) post-intervention. A chi-square test comparing pre- and post-intervention proportions showed a statistically significant difference $\chi^2 (1, N=584) = 15.5, p < .0005$, indicating that the intervention was associated with a meaningful improvement in DEXA ordering.

Conclusions: Providing PCPs with lists of patients due for DEXA screening, paired with team education on the importance of osteoporosis screening and streamlined workflows, represented a novel and effective strategy to enhance osteoporosis screening rates. Limitations of our study included difficulties with efficient DEXA scheduling (up to 6 month wait time for scans), leading to a pivot in outcome measure from DEXA scans completed to those ordered. Additional limitations included an inability of software to find distant or external DEXA results, and to exclude patients for whom a DEXA was not indicated.

A236

Social Isolation and Loneliness: Prevalence and Influence of Caregiver at the VA Home Based Primary Care Program

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Background: Social isolation and loneliness (SIL) are linked to serious health risks and 40% of adults over sixty reports feel lonely, yet SIL had not been studied in the VA Home-Based Primary Care (HBPC) population. HBPC supports individuals over sixty-five who have difficulty accessing routine healthcare. This project initially aimed to measure SIL among HBPC participants, explore its causes, and identify solutions. Surveys were piloted using the Lubben Social Network Scale-6 and the Berkman-Syme Social Network Index (SNI) 11-item questionnaire. Due to participant fatigue, the shorter Berkman SNI-4 was adopted. Noticing that many homes had paid caregivers, researchers added questions to explore whether caregiver presence affected SIL, adjusting the study aims to include prevalence and caregiver influence in SIL. **Methods:** Twenty-seven HBPC participants were surveyed by convenience sampling using the SNI-4, UCLA Loneliness questionnaire, and caregiver-specific questions and analyzed statistically with percentages, standard deviation, t-test and chi-square. **Results:** Among 27 participants (mean age 79.5), 19% were female, 81% male; 30% were married or in a committed relationship, 70% were not. Living arrangements included alone (44%), with other residents (15%), with caregivers (15%), and with pets (26%). Most lived in private homes (74%), with others in senior apartments/assisted living (22%) or medical foster homes (4%). Rural residents comprised 78%, urban 22%. SIL was present in 44.44% of participants; 55.56% did not experience SIL. Caregivers were present for 56%. The presence of caregivers was not significantly associated with reduced social isolation ($p = 0.185$) or loneliness ($p = 0.414$). The absence of social isolation was much more common when caregivers were considered part of the social group (7 out of 8 cases versus 1 out of 8, $p = 0.0027$). Loneliness was more likely among those whose caregivers were considered part of their social group ($p = 0.035$). Absence of loneliness varied significantly by loneliness score ($p = 0.0037$). **Conclusion:** SIL prevalence in HBPC matches literature reports for older adults. Integrating caregivers into patients' social circles is associated with reduced social isolation, but not loneliness.

A237

Loneliness Matters: A Quality Initiative to Elevate Screening in Geriatric Care

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Background:

Loneliness increases risk of cardiovascular disease, dementia, stroke, depression, anxiety, and premature death¹. While the Medicare Annual Wellness Visit (AWV) requires routine depression screening via the Patient Health Questionnaire (PHQ) 2/9, there is no systematic loneliness screening. A 2024-2025 quality improvement (QI) initiative at the Center on Aging (COA), an outpatient geriatrics clinic at New York Presbyterian/Weill Cornell Medical Center (NYP/WCMC), temporarily increased loneliness screening rates at AWVs but this change was not sustained. This project aims to sustainably increase screening rate at AWVs at the COA by 30% from February to May 2026.

Methods:

This QI project is being conducted at an academic outpatient geriatric clinic (COA) at NYP/WCMC in New York City, serving about 3,000 patients aged 65 and older. Initial interventions included screening patients with a paper form of the UCLA 3-Item Loneliness Scale (UCLA-3) during their AWV by front desk staff and creation of a doctphrase in the electronic health record (EHR) for providers to document. Patients with a positive screening of ≥ 4 were given a list of resources. Reminders were placed in exam rooms and providers were educated on the new workflow. Data is collected by manual EHR review.

Results:

From February to May 2025, 148 AWVs were conducted at the COA with an increase in UCLA-3 screening rates from 0% to 15.8%. Of those screened, 21.2% were positive for loneliness. 71.4% of patients with a positive UCLA-3 did not screen positive for depression on their PHQ-2. A recent chart review of 161 AWVs at the COA from 9/1-11/25/2025 found that 0% patients received UCLA-3 screening, showing a return to the pre-intervention baseline.

Conclusion:

Loneliness is common amongst older patients and associated with worse outcomes. Depression and loneliness screenings do not overlap, indicating the importance of separate screening. Although a prior QI initiative increased loneliness screening, the effect was temporary. Utilizing structured staff training and EHR modification, we plan to sustainably increase screening rate.

Reference:

1. Holt-Lunstad J. Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community. U.S. Department of Health and Human Services; 2023.

A238

Breaking the PPI Habit: A Structured Review to Reduce High-Risk Medications

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Background: Polypharmacy is prevalent among nursing home (NH) residents and is associated with worse outcomes such as side effects, hospitalizations, and falls. We implemented a structured medication review and deprescribing protocol to reduce high-risk medication use in NH residents.

Methods: We reviewed medication regimens for 29 veterans on a single long-term care unit in a VA Community Living Center (CLC) using Theradoc to identify potentially inappropriate medications (PIMs) per 2023 AGS Beers Criteria. Chart reviews assessed

polypharmacy (defined as ≥ 5 medications), medication indications, effectiveness, and prior deprescribing attempts. Findings were first reviewed at deprescribing meetings with clinical providers and pharmacists. They were then presented at scheduled Interdisciplinary Team (IDT) meetings involving providers, nursing, other NH staff, veterans, and their representatives, to offer deprescribing plans using shared decision making. Veterans were monitored for symptom recurrence and re-prescribing at 2 weeks and 3 months.

Results: Polypharmacy was observed in 97% of veterans, with an average of 13.6 scheduled medications per veteran. Among these, 93% received at least one PIM, totaling 87 prescriptions for 26 unique medication classes. Proton pump inhibitors (PPIs) were the most frequently prescribed, accounting for 17% of all PIM prescriptions. Fifty-eight percent of veterans were receiving PPIs and 87% lacked a clear indication for long-term PPI use. During two IDT review cycles, 7 veterans were discussed, 4 of whom had PPI prescriptions. IDT review led to deprescribing of 75% of PPIs for reviewed veterans.

Conclusion: While CLC pharmacists conduct comprehensive reviews with an emphasis on high-risk medications such as psychotropics and anti-hypertensives, PPI use is not yet routinely evaluated. Our findings demonstrate that the majority of patients on PPIs may benefit from deprescribing trials. PPIs are considered PIMs due to their association with *C. difficile*, fractures, and malignancy and should be part of structured medication reviews in the NH setting. Future cycles will include implementation of provider and pharmacist education on appropriate PPI use and deprescribing.

A239

Analysis of the Evaluation and Management of Restless Leg Syndrome Following 2025 Guideline Update at the Atlanta Veterans Affairs

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Background

Restless Leg Syndrome (RLS) is a distressing condition that significantly affects quality of life, and its prevalence increases with age. In January 2025, updated societal guidelines discouraged dopamine agonist use and prioritized iron deficiency screening and other pharmacological treatments. This quality improvement (QI) project aims to assess the evaluation and management (E/M) practices for RLS at the Atlanta Veterans Affairs (VA) and compare two primary care settings within the Atlanta VA: geriatric primary care clinic (GPCC) and home based primary care (HBPC). In addition, we aim to identify gaps and inform future targeted interventions to improve the E/M of RLS at the GPCC.

Methods

We analyzed practice patterns in RLS management of patients aged 65 years or older in different primary care settings within the Atlanta VA, across two timeframes: pre and post guideline update (June 2023–December 2024; January–September 2025). Different comorbidities, screening of iron deficiency, and pharmacologic treatment were reviewed.

Results

There are 1,150 patients ≥ 65 years old diagnosed with RLS at the Atlanta VA. Of those patients, 2.4% (n=28) obtain primary care at the GPCC while 1.1% (n=13) participate of the HBPC. Demographic data for Atlanta VA patients with a diagnosis of RLS was significant for white and male predominance (71.6% and 92.4%, respectively), 0.8% of patients were Hispanic. The most common comorbidity was diabetes mellitus (41.2%), followed by iron deficiency anemia (7.9%), and peripheral neuropathy (5.3%). Iron deficiency screening was completed in 59% of patients globally (Atlanta VA - 58.7%, GPCC - 64.3%, HBPC - 69.2%). Only 54.1% of patients with a diagnosis of RLS receive pharmacological treatment. Of 8,586 prescriptions, the

most prescribed medication class is gabapentinoids (60%), followed by dopamine agonists (31%), and finally iron replacement (9%).

Conclusions

The societal guideline update describes best practices in RLS management. We continue to analyze prescription tendencies in addition to pre and post guideline update trends within each cohort. These preliminary findings support targeted QI efforts in education to primary care providers to improve iron deficiency screening and decrease of dopamine agonists treatment in patients with RLS.

A240

Retrospective Application of the Mitchell Mortality Prognostic Score in Skilled Nursing Facility Residents

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Background/Significance

Accurate prognostication is essential for supporting goal-aligned care among skilled nursing facility (SNF) residents. The Mitchell Mortality Prognostic Index, developed and externally validated primarily in residents with advanced dementia, is widely used to estimate 6-month mortality risk. Its performance in more clinically heterogeneous SNF populations applied six months prior to death in real-world long term care settings is not well characterized.

Objectives

To evaluate concordance between retrospectively calculated Mitchell Index scores and observed 6-month mortality among SNF residents.

Methods

We conducted a retrospective chart review of 19 residents who died in a single SNF between 2020 and 2025. For each resident, the Mitchell Index was reconstructed using clinical data from six months prior to death. Total scores were calculated and categorized using published risk ranges corresponding to estimated 6-month mortality probabilities.

Results

Mitchell scores ranged from 4.3 to 19.1 (mean 11.0; median 11.3) corresponding to a predicted 6-month mortality risk from 7% to 62%. 47% (9/19) of residents fell into groups associated with a $\geq 23\%$ predicted 6-month mortality, and 37% (7/19) fell into categories associated with a $\geq 28\%$ predicted mortality. Only 2 residents (11%) scored in the highest-risk categories ($\geq 34\%$ predicted mortality), and 1 resident (5%) had a score >16.1 points, corresponding to an estimated 49–62% mortality risk. Despite all residents dying within six months, more than half (53%) had Mitchell scores below commonly cited high-risk thresholds. Among residents with high prognostic scores, markers of advanced functional decline were more frequently present.

Conclusion

In this retrospective cohort, Mitchell Mortality Index scores frequently fell below established high-risk thresholds even though all residents died within six months. Because the Mitchell Index was externally validated primarily in residents with advanced dementia, its performance in a mixed skilled nursing facility population may differ. These differences likely contributed to the lower-than-expected proportion of residents meeting high-risk thresholds in our cohort. These findings suggest that the index may under-estimate mortality risk outside advanced dementia populations and highlight the need for prognostic tools tailored to the diverse clinical trajectories encountered in long-term care.

A241

Improving Vitamin D Supplementation Rates in Older Adults with Osteoporosis

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Background:

Osteoporosis affects approximately 27% of women and 5.7% of men over the age of 65 in the United States according to the US Preventative Services Task Force.¹ Current guidelines by the American Association of Clinical Endocrinologists recommend 800-1000 IU of Vitamin D3 (cholecalciferol) daily for patients with osteoporosis to optimize bone health and response to therapy.² The target serum 25(OH)D level for patients with osteoporosis is generally considered to be ≥ 30 ng/mL, but there is no specific guideline for checking routine vitamin D levels in patients with osteoporosis.² The study's primary aim is to start patients with osteoporosis not taking vitamin D on supplementation.

Methods:

The study is a retrospective review of community-dwelling patients ≥ 65 years of age who are cared for at two geriatric primary care clinics. A report was generated through the EHR of patients with diagnosis of osteoporosis. The data was de-identified and exported to an Excel spreadsheet for analysis. Data collected from the report included age, gender, diagnosis of osteoporosis, taking or not taking vitamin D, and last vitamin D level with date. Patients without vitamin D recorded on their medication list were identified for intervention. The patient's PCPs were messaged through the EHR with recommendations to consider starting their patient on vitamin D. The message provided most recent vitamin D level with date collected and recommendations on avenues for contacting patients. The primary outcome measured initiation of vitamin D supplementation in patients with osteoporosis at 8 weeks following intervention. The secondary outcome evaluated how many patients not on vitamin D had a recent, normal vitamin D level; indicated by 25(OH)D level ≥ 30 ng/mL in the past 12 months.

Results:

59 out of 259 community-dwelling patients ≥ 65 years of age with osteoporosis at both primary care clinics were not recorded to be taking vitamin D supplementation. The study population was mostly female with average age of 82. Of the 59 patients identified, 25 had recent vitamin D levels and 21 were in the normal range. Preliminary data showed increased rates of vitamin D initiation following intervention.

Conclusion:

EHR based PCP messaging facilitates initiation of vitamin D supplementation in patients with osteoporosis.

References:

1. JAMA. 2025;333(6):498-508.
2. AACE. 2020;26(1):1-46.

A242

Incorporating Structured Frailty Assessment for Older Adults Hospitalized with Newly Diagnosed AML: A Quality Improvement Project

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Background:

Older adults represent the majority of new acute myeloid leukemia (AML) diagnoses. Yet, frailty assessment is rarely incorporated into initial inpatient care, despite frailty measures being predictors of survival and healthcare utilization. We designed a Quality Improvement (QI) project aimed at implementing the Comprehensive Geriatrics Assessment Frailty Index (CGA-FI) (1) during early hospitalization of older adults with new diagnosis of AML in a tertiary academic medical center, with the aim of identifying vulnerabilities and guiding care and interventions.

Methods:

We conducted two education sessions with the nursing staff of the hematological malignancies inpatient floor aimed at coaching on the utilization and implementation of the CGA-FI. To determine feasibility of implementation, we conducted a side-by-side comparison of the assessment done by staff who completed the CGA-FI vs a CGA completed by the geriatrics inpatient consult team (standard of care) on adults ≥ 65 years who had a new diagnosis of AML, within five days of admission to the hospital, in a three month period.

Results:

Using QI methodology, we conducted Plan-Do-Study-Act (PDSA) cycles to refine the utilization of the CGA-FI in assessing the level of frailty of adults ≥ 65 years hospitalized with new AML diagnosis compared to the standard of care. After each completed assessment, we identified challenges and opportunities in the utilization of the CGA-FI tool, allowing for perfecting its standardization prior to wider utilization in assessment of frailty and triggering the implementation of a structured frailty assessment pathway for these patients.

Conclusions:

Early identification of frailty in acutely ill hospitalized older adults with new diagnosis of AML predicts survival and healthcare utilization. With judicious utilization of tools like the CGA-FI for frailty screening in these patients, it is possible to implement pathways of interdisciplinary team collaborations to improve overall care.

Further implementation outcomes of this QI project included the determination of feasibility, creating and adhering to the assessment pathway, and integration of frailty findings into clinical decision-making.

Bibliography:

1. <https://efrailty.hsl.harvard.edu/tools/CGA-FI/index.html>

A243

"Hit Me with Your Best Shot:" Improving Influenza Vaccination Rates in Adults ≥ 65

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Background: Influenza remains a significant public health threat among older adults due to weakened immunity and comorbidities, with those 65 and older accounting for most flu-related hospitalizations and deaths. Annual vaccination is the most effective intervention to reduce complications, hospitalizations, and mortality in this high-risk population. Several vaccine formulations for older adults are designed to boost immunogenicity, producing stronger antibody responses than standard doses to compensate for age-related immunity decline. Despite strong evidence supporting vaccination, barriers such as hesitancy, misinformation, and limited access among homebound elders persist. Healthcare professionals can improve vaccination rates by offering vaccines during routine visits and providing culturally sensitive education on their safety and benefits.

Aim: This quality improvement (QI) project aims to achieve a minimum of 70% influenza vaccination coverage among adults 65 and older in a rural hospital-based geriatric clinic within three months of implementation.

Methods: Key interventions will focus on educating geriatric clinic nursing staff and patients. Patient education will occur in three phases. Nursing staff will offer the flu vaccine during the rooming process; providers will reinforce this education with a detailed brochure, and information about the influenza vaccine will be added to the EPIC "patient instructions" tab and discharge paperwork.

Results: This project is expected to increase flu vaccination coverage among older adults and reduce missed opportunities, strengthening the clinic's capacity to deliver evidence-based preventative care, improve outcomes, and foster a culture of healthy older adults.

Conclusion: Systematic, team-based, and equity-focused strategies can substantially improve immunization rates, especially influenza, and enhance preventative care for older adults.

A244

Chronic Care Management: A Clinical Conundrum

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The Chronic Care Management (CCM) program was first debuted in 2015 by the Centers for Medicare & Medicaid Services (CMS) as a means of incentivizing the active support of patients with two or more chronic medical conditions within the outpatient setting. The aim of this program in encouraging proactive care of this patient population is to improve patient outcomes as well as quality of life, and to resultantly reduce healthcare costs in the process. CCM has also become an increasingly prominent modality for improving financial viability of primary care practices, particularly those with populations who have a high burden of chronic medical conditions such as geriatric medicine. However, CCM continues to be a severely underutilized service with recent data showing that only 4% of Medicare beneficiaries eligible for CCM are actually enrolled in the program. This results in missed opportunities to provide higher-quality medical care and access an additional revenue stream for healthcare practices. While our local academic geriatric medicine practice has far surpassed the national average in enrollment after a dedicated effort, significant barriers to further integration of CCM include lack of provider and staff knowledge of the program, inertia in enrolling new patients, and low uptake of provider CCM coding behaviors. Our aim is to assess and augment current strategies for increased clinician coding implementation in order to buttress continuity and practice revenue. Using a QI framework and PDSA cycles, we reviewed a standardized workflow for CCM identification and enrollment. Planned interventions for increased billing activity include EMR smart phrases, quick-reference pocket cards, and targeted education during weekly clinical meetings. In doing so, our goal will be to increase CCM coding utilization by at least 25% over a six-month period. We believe that this education and standardization will result in increased revenue and strengthen the long-term viability of the geriatric medicine practice at Massachusetts General Hospital. Data collection is ongoing at this time, but will be presented upon project completion.

A245

Use of Comprehensive Geriatric Assessment in Pre-frail and Frail Kidney Transplant Candidates

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Background: Older adults are a growing proportion of KT candidates and have generally shorter times on the waitlist before risks of transplant outweigh expected benefits to lifespan. The 2020 Kidney Disease Improving Global Outcomes (KDIGO) Clinical Practice Guidelines for KT candidates recommends assessing frailty status in older transplant patients. Frailty is associated with poorer post-transplant outcomes yet remains potentially modifiable. A comprehensive geriatric assessment (CGA) may identify additional factors contributing to frailty status that may otherwise be overlooked during the KT evaluation process.

Methods: The Froedtert & MCW Kidney Transplant team screens for frailty using the Fried Frailty Assessment (FFA) as part of assessment for transplant candidacy. Patients age 65+ who scored $\geq 1/5$ on FFA (pre-frail or frail) were referred to an outpatient geriatrics clinic for CGA by a geriatrician, which included frailty and cognitive screening measures. Recommendations and referrals were based on the Geriatrics 5Ms Framework. This quality improvement project characterized the referred KT candidate patients over a 16-month period (8/1/2024-12/1/2025) through review of appointment documentation.

Results: 18 transplant candidates meeting frail or pre-frail met referral criteria; 15 (83%) underwent CGA. Average age of patients

undergoing assessment was 72.7 yrs at time of geriatric evaluation, and 2/15 (13%) identified as women. Patients undergoing evaluation had a mean FFA of 2.4, with median FFA 2. 7/15 (47%) remain in evaluation for KT listing. The most commonly identified condition on geriatric assessment was physical frailty, with other notable geriatric syndromes identified including cognitive decline and polypharmacy. The most common recommendation made was initiation of physical therapy. At this time, no patients assessed under this protocol have undergone kidney transplant.

Conclusions: CGA is effective for identifying additional geriatric syndromes in older KT candidates and generating recommendations for addressing potentially modifiable contributors to frailty. Continued use of CGA as an adjunct assessment for KT candidacy will ideally optimize these patients for peri-transplant success. Further work is needed to evaluate adherence to recommendations and long-term outcomes.

A246

Perceived Long-Term Utility of a Pre-Operative Comprehensive Geriatrics Assessment Template: A Quality Improvement Project

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Background: Older surgical patients experience higher perioperative risks, which can be discovered and mitigated through pre-operative Comprehensive Geriatrics Assessments (CGA) (1). A quality improvement (QI) project was designed and implemented to improve pre-operative care for adults ≥ 65 years through a standardized template. Implementation of the template demonstrated its feasibility and usability within the workflow of a geriatrics ambulatory clinic. An analysis evaluating the perceived long-term value of the pre-operative CGA was done. We hypothesized that the template used during peri-operative planning provides clear documentation of patient values, functional baselines, and cognitive trajectories guiding longitudinal care.

Methods: A survey of geriatricians and surgical specialists regarding the perceived utility of the pre-operative CGA was undertaken. Survey domains included clarity of documented goals, relevance of baseline cognition and mobility to future decision-making, and overall impact on future continuity of care.

Results: Preliminary results demonstrate that surgical specialists value domains directly affecting perioperative risk stratification, including frailty, cognition, and medication review. Geriatricians reported additional downstream benefits, particularly patients' preferences, functional baseline, and evolving cognitive status. Both groups agreed that the pre-operative CGA improves communication, with geriatricians perceiving greater long-term utility.

Conclusion: A pre-operative CGA template for adults ≥ 65 years is feasible to implement in the geriatrics ambulatory settings, adding value to both surgical and medical teams by strengthening continuity of care, enhancing shared decision-making, and supporting goal-concordant care beyond the operative period.

References: 1. Guidry CA et al. *J Am Geriatr Soc.* 2021; "Comprehensive geriatric assessment in surgical patients."

A247

Targeted Bone Health Review for Continuing Care Retirement Community (CCRC) Residents with Prior Falls: A Quality Improvement Initiative

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Background: Osteoporotic fractures in long-term care (LTC) residents are a critical, costly problem¹. Residents of CCRCs with falls are a high-risk group, yet osteoporosis treatment remains suboptimal². We implemented a pharmacist-geriatrician quality improvement

initiative for systematic bone health review for CCRC residents with prior falls to quantify gaps in pharmacologic treatment of osteoporosis with calcium, vitamin D, and antiresorptives.

Methods: In 2025, we conducted a retrospective EHR chart review at a single 90-bed CCRC. We included all LTC residents with ≥ 1 documented fall. We abstracted demographics, frailty (via FRAil), renal function, fracture history, FRAX risk (when available), hospice status, and therapy use plus refusals/contraindications. High fracture risk was defined as prior fragility fracture and/or $\text{FRAX} \geq 20\%$. Outcomes were treatment rates overall among high-risk residents, and proportion of high-risk residents without antiresorptives or documented reasons before intervention.

Results: 69 out of 70 residents had ≥ 1 prior fall; median age was 90 years (interquartile range 86–94). Overall, 23/69 (33%) had a prior fragility fracture (6 hip). FRAX was available for 29 residents (median 21%); 18/29 (62%) had $\text{FRAX} \geq 20\%$. Among all fallers, 42/69 (61%) received calcium, 59/69 (86%) vitamin D, and 32/69 (~46%) had current or recent antiresorptive therapy. Using our composite definition, 29/69 (42%) were high fracture risk; among them, 19 (66%) received calcium, 26 (90%) vitamin D, and 17 (59%) an antiresorptive. 12/29 (41%) high-risk residents lacked antiresorptives; only 4/12 (33%) had hospice, renal contraindication, or refusal documented, leaving 8/29 (28%) high-risk fallers without therapy or a clear rationale.

Conclusions: In this real-world, high fall-risk CCRC cohort, osteoporosis pharmacotherapy remained underused despite clearly elevated fracture risk and widespread vitamin D use. A systematic, pharmacist–geriatrician review triggered by falls is a scalable, actionable strategy to identify and close osteoporosis care gaps, with potential to improve fracture prevention and goal-concordant care in CCRCs. For the next cycle, we will create a bone health checklist for monthly fall rounds and reassess for increase in therapy.

A248

Medicare Annual Wellness Visits: Springboard to Age-Friendly Health System Transformation in Primary Care

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Background: Annual Wellness Visits (AWVs) are a foundational Medicare benefit with untapped potential to advance age-friendly care. In 2019 Virtua Health, the largest regional health system in South Jersey, implemented the AWW across primary care practices, with a goal of increasing completion rates over time. In 2024 Rowan-Virtua School of Osteopathic Medicine and Virtua Health, as partners on the DHHS-HRSA Geriatrics Workforce Enhancement Program (GWEP), committed to developing a scalable, sustainable, dementia-capable geriatric service line and attaining IHI Age Friendly Health System (AFHS) recognition built on the 4Ms framework (What Matters, Medications, Mentation, Mobility). Incorporating the 4Ms into the AWW is a strategy to increase completion rates, track outcomes, support workforce development, and achieve AFHS status.

Methods: Level 1 AFHS status was achieved for 36 primary care practices in January 2025. Ongoing quality improvement (QI) and clinician/staff training on the 4Ms was provided for all sites. Structure and process changes informed by provider feedback included Epic enhancements (e.g., activating the 4Ms tab, customizing data entry screens/templates, aligning 4Ms in the Epic dashboard), workflow redesign, adding a digital cognitive screen, nurse-led AWWs, patient outreach, and schedule optimization using “piggyback appointments.” Data submission for Level 2 AFHS status is anticipated in January 2026.

Results: In 2019, AWW completion rates were 6% ($n=2,014$) out of 33,172 eligible patients. Addressing barriers and workflow changes to incorporate the interdisciplinary team (e.g., CMA, RN) in

AWV implementation resulted in completion rates increasing to 22% ($n=15,842$) of 72,735 eligible patients through Q3 of 2025, with RNs completing 33% ($n=5,180$) of the AWWs.

Conclusions: Integration of the 4Ms framework into Epic, ongoing provider training, workflow redesign, a nurse-led delivery model, and implementation of an AI digital cognitive screen into the AWW can accelerate Age-Friendly Health System transformation. As a gateway to preventative care, AWWs offer a pathway to facilitate early detection of cognitive and functional impairment – areas with significant potential for a sustainable clinical investment.

A249

Optimizing Hypertension Management in a Primary Geriatrics Clinic

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Background:

Hypertension (HTN) is a risk factor for heart disease, dementia, and mortality, but is challenging to control in geriatric patients. While the HTN benchmark set by Centers for Medicare & Medicaid Services (CMS) is 75% of patients aged 75–85 maintaining blood pressure (BP) below 130/80, our clinic is still following the Mount Sinai Health Partners goal of 140/90. In our urban academic primary care geriatrics clinic, only 72% meet this latter blood pressure goal. Using an electronic medical record (EMR) smartset, we aim to reach a target of 75% by June 2026.

Methods:

Our current management options for patients with uncontrolled HTN include the following: follow-up calls by nursing, referral to the remote blood pressure monitoring program, referral to Cardio-HTN clinic and using the HTN smartset. The HTN smartset includes first-line, step-up and combination antihypertensives, ordering protocol for home blood pressure monitors, educational material, referrals and ICD coding. We surveyed clinic attendings, fellows, and nurse practitioners about their knowledge of the HTN management workflow, confidence in locating the HTN smartset and perceived barriers in utilizing the smartset. Attendings were educated on HTN management workflow and the smartset itself; educational materials were sent to fellows via email. We will compare, chart review, and EPIC query data following these educational interventions to assess for improvement, with plans to iteratively modify and improve the care model over the next 6 months.

Results:

Data was obtained for patients between 75–85 years old with uncontrolled HTN from October 2025 to December 2025. 237 out of 834 clinic patients had a BP above 140/90. The smartset was utilized for 15 patients, predominantly by attending physicians. Barriers to using the HTN smartset include difficulty locating, appropriately using and incorporating it into the workflow.

Discussion:

We identified consistent under-utilization of the clinic HTN workflow, likely due to lack of awareness and difficulty incorporating the EMR smartset. We anticipate that with education focused on utilization of the HTN smartset, we will improve HTN management.

A250

When Wi-fi Fails, Pamphlets Prevail: Boosting Rural Geriatric Access the Old-School Way

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Background: Older adults in Lafayette and surrounding rural parishes in Louisiana experience reduced access to geriatric specialty care due to geographic, informational, and resource-related barriers. Previous needs assessments revealed that many rural older adults

and caregivers were unaware that comprehensive geriatric assessments, cognitive evaluations, and caregiver support services were available locally. Community outreach strategies, including low-cost print materials, have been effective in other underserved populations but remain underutilized in geriatric care delivery. With this quality improvement (QI) initiative, we hope to increase rural engagement by distributing culturally appropriate, easy-to-read informational pamphlets across high-impact community sites. Increasing awareness of available geriatric services may facilitate earlier engagement and improved health outcomes.

Purpose: This QI project aims to increase new geriatric patient referrals from rural and surrounding parishes of a hospital-based clinic by developing and distributing educational pamphlets that describe comprehensive clinic services.

Methods: Using a Plan-Do-Study-Act (PDSA) framework, the geriatrics team will design a patient friendly trifold pamphlet highlighting geriatric services, referral pathways, appointment options, common geriatric syndromes, and contact information. Pamphlets will be distributed weekly to community locations frequently visited by older adults (e.g. senior centers, churches, pharmacies, restaurants, primary care offices, local markets, and libraries). Intake staff will systematically capture: (1) parish of residence, (2) how they heard about the clinic, (3) inquiry type, and (4) whether the pamphlet influenced scheduling. Data will be collected for 3 months, post-implementation. A voluntary patient survey at intake will be conducted to assess pamphlet clarity, relevance, and usefulness.

Expected Outcomes: As a result of this QI project, we hope to demonstrate a measurable increase in the number of new patient referrals from targeted rural parishes. Secondary outcomes will include pamphlet usefulness ratings, identification of effective community distribution sites, and enhanced awareness of available geriatric services.

Significance: This project may provide a scalable, low-cost model for rural outreach to improve access to geriatric specialty care in underserved regions of Acadiana.

A251

Educating Providers to Improve Recognition and Integration of SDOH in Geriatric Care

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Background:

In the geriatric population there is unassailable evidence of a causal relationship between social risk and multiple common disease states including Alzheimer's, cardiovascular disease, and frailty. Thus, it is critical geriatric primary care providers address the social barriers challenging their patients' health. The aim of this QI project is to educate providers on the importance of screening for SDOH (social determinants of health) in the geriatric patient population and plan individual- and health care system-level interventions to improve health outcomes.

Methods:

We initially surveyed providers delivering care at the four University of Michigan Geriatric Primary Care Centers. This baseline survey evaluated their existing practice to screen for SDOH and their knowledge of the follow-up procedure for positive screens. Responses were summarized using descriptive statistics, and qualitative comments from the open-ended question were systematically categorized into thematic domains.

Results:

Out of 27 geriatric providers invited, 12 completed the survey. The results are summarized in Table 1.

Conclusions:

In this survey of geriatric PCPs, the majority were unfamiliar with how to locate responses to SDOH screens within the EHR and did not routinely review results. Nearly half were "not at all confident" regarding the recommended follow-up procedures for a positive screen. Along with open-ended comments showing interest in targeted training related to these processes, our findings underscore the need to develop formal educational offerings to promote effective utilization of SDOH data in the EHR. Accordingly, a divisional noon conference is scheduled for January 2026 to educate providers on the significance of SDOH screening practices in the older adult population. Providers will then be invited to take a post-intervention survey to help evaluate the impact of the educational program on provider knowledge of SDOH and confidence implementing follow-up procedures. Ultimately, this initiative has the potential to enhance health outcomes among a vulnerable older adult population.

Table 1: Knowledge and practices regarding SDOH screening among geriatric pcps (n=12)

Questions	Yes	No
Do you know where to find a patient's response to the SDOH questionnaire in MyChart?	5 (41.7%)	7 (58.3%)
Is the patient's response to the SDOH questionnaire integrated into any of your office visit note templates?	3 (25%)	7 (58.3%) (2 (16.7%) were unsure)
Do you routinely review patients' responses to the SDOH questionnaire?	3 (25%)	9 (75%)
How confident are you in understanding the next steps required for a positive SDOH screening result (i.e., how to address identified needs)?	Very confident 0 (0%) Somewhat confident 7 (58.3%) Not at all confident 5 (41.7%)	
Themes from open-ended comments:	1) Enthusiasm and interest in training on this topic (n=4) 2) Comments on the SDOH form itself (n=2, e.g., "font is too small," "needs question about urgency of needs")	

A252

Deeper Dive Into Age-Friendly: Improving Delirium Detection and Response for Hospitalized Veterans

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Background: The Confusion Assessment Method (CAM) was implemented at the West Los Angeles Veterans Administration (VA) hospital for delirium screening as part of the Age-Friendly Health initiative and incorporated as a mandatory component of nursing shift assessments. However, it was unclear whether CAM assessments were meaningfully driving delirium detection, management, or preventive actions. Using principles of implementation science, we sought to evaluate whether our existing CAM workflow triggered timely clinical response. By June 2026, we aim to increase by 25% the proportion of hospitalized veterans aged ≥65 with a positive CAM who receive documented delirium management actions through a multitude of targets including resident medical education, nursing champion retraining, and structured team huddles.

Methods:

Baseline data was collected by chart review of positive CAMs to assess documentation of management actions (e.g., medication review, delirium precautions). To identify workflow barriers, we performed a Gemba Walk with frontline nursing staff and a root cause analysis using a fishbone diagram. Findings were synthesized into an impact-effort prioritization matrix to guide intervention targets and initial PDSA cycles.

Results:

Among 31 positive CAMs, only 10% were correctly completed. Delirium was documented by physicians in 9 cases, with only 2 (22%) aligning with nursing assessments. Forty percent of patients had dementia and others had psychiatric comorbidities. The Gemba walk identified gaps in the following areas: determining baseline cognition, wide variability in assessing "attention" and "disorganized thinking", and CAM scoring.

Conclusions:

Evaluating the implementation of the CAM through a structured implementation science framework revealed critical workflow and knowledge gaps limiting its utility. Priority interventions will include simplifying nursing CAM template (high-impact, low effort), creating accessible concise guides and tip sheets in high-traffic areas (high impact, low effort), and nursing and champion retraining (high impact, high effort). These improvements aim to enhance the clinical utility of the CAM and advance Age-Friendly Health System goals for hospitalized older veterans.

A253

Developing an AI-Powered Fellowship Logistics Chatbot to Support Geriatrics and Palliative Care Fellows' Well-Being: A Pre-Implementation Survey

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Background

The geriatrics and palliative medicine fellowship program at Mount Sinai is the largest in the country, currently supporting 32 fellows across 7 different tracks. Each rotation has its own schedule, workflow, and set of fellow expectations and this information has become fragmented across multiple platforms, including SharePoint, Google Drive, phone applications, emails, and verbal handoffs. Fellows often report difficulty in finding reliable information and feeling prepared for their rotations. Our team initiated a project to build an AI-powered chatbot for fellowship logistics to make this process more efficient, with the goal of ultimately improving fellows' well-being.

Methods

A pre-implementation survey was conducted to characterize the information gathering practices of fellows prior to the start of their rotations. The survey assessed the following: baseline characteristics of the fellow, time spent on pre-rotation information gathering, perceived difficulty and confidence in locating necessary information, perceived significance of possible barriers, and expectations for the AI-powered chatbot.

Results

Responses were obtained from 9 fellows across 5 different training tracks. At baseline, 6/9 (66.7%) of fellows used AI tools for work or learning a few times per week or more. 3/9 (33.3%) of fellows required more than one hour each week to find logistics information. 5/9 (55.6%) of fellows did not feel confident or prepared that they had the information needed. Among the potential barriers to information gathering, information being scattered across different platforms and difficulty locating pertinent files were identified as significant. 7/9 (77.8%) of fellows expressed a preference for having the source of the information provided by the chatbot.

Conclusions

Gathering information across multiple sources prior to rotations can be time-consuming and stressful for fellows, which can negatively impact well-being. Our pre-implementation survey provides baseline knowledge on the extent of current barriers and how an AI-powered chatbot can be structured as a reliable single source of information for fellows with accurate information and links to original resources.

A254

Early Ambulation in the ED to Reduce Hospital LOS in Geriatric Patients

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Background: It can be difficult to ambulate patients in the Emergency Department (ED) due to acute illness, imposed immobility, and staff shortages (1). ED holding times may be 175 minutes or longer (2). However, increasing patient mobility is known to reduce

average length of stay (ALOS) (3). In 2024, the ALOS at our institution was 5.4 days (4). This quality improvement project aimed to understand the impact a dedicated Patient Care Technician (PCT) ambulating patients in the ED had on ALOS for geriatric patients in our institution.

Methods: This was a quality improvement project at a Level I Trauma Center in southwest Virginia. Between February and March 2025, 23 patients were ambulated by a PCT in the ED before admission. Age, gender, race, ALOS, and the number of times ambulated by the PCT in the ED were analyzed via descriptive analysis. ALOS was then compared to the 2024 ALOS of our institution.

Results: The average age of the mobilized group was 79.4 years, comprising 11 females, 12 males, 2 black patients, and 21 white patients. The mobilized group ambulated an average of 1.8 times with a PCT in the ED. The ALOS for the mobilized group was 3.8 days (vs. 5.4 days).

Conclusions: Geriatric patients who ambulated with a PCT had a reduced ALOS in comparison to our institution's ALOS. However, more data on this topic is needed to prove causality. Future projects would benefit from a larger sample size and the minimization of confounding variables.

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A255

Improving Psychosocial Screening, Health Care Proxy and Care Partner Identification in Patients Being Evaluated for Monoclonal Anti-Amyloid Therapies

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Introduction

Anti-amyloid monoclonal antibodies (mAbs), the first disease-modifying therapies for Alzheimer's disease (AD), have transformed the treatment landscape but pose major implementation challenges beyond the requirement for apolipoprotein E (APOE) testing, confirmed presence of beta amyloid pathology, infusion capacity and MRI monitoring. Often forgotten is the need for health care proxy (HCP) and care partner identification. Most electronic medical records (EMR), lack the necessary psychosocial data and may require additional steps for care partner (CP) identification.

Methods

To increase information quality and selection process efficiency for mAbs therapy, a multidisciplinary team at the New York University Langone Health developed a standardized workflow and Care Partner Identification Social Screening, launched in October 2025 and piloted for 3 weeks. The form, completed by new patients, those signing APOE consents or undergoing beta-amyloid testing, includes HCP status, care partner availability, and living situation (live alone, live with someone involved in care, or with someone not involved in care). Assessments are scanned into the EMR. Physicians refer patients diagnosed with cognitive impairment and unable to identify a HCP, a care

partner or living alone. Using the EMR, we measured the frequency of completed assessments, the proportion of patients who identified their HCP and care partner, and those meeting referral criteria to SW.

Results

Of 21 patients meeting screening criteria, 20 (95%) completed the questionnaire. Seventeen patients (85%) identified a HCP, including 3 who completed a new HCP form and 14 already had one documented. Fourteen (70%) lived with someone involved in their care while 6 lived alone. Four patients did not have a care partner available for medical appointments, including 3 of those living alone. Four (20%) diagnosed with Mild Cognitive Impairment were referred to SW (3 for HCP identification, 1 living alone).

Conclusion

Standardized psychosocial screening efficiently identifies HCP, Care Partner and patients in need of further SW intervention and may improve the safety and coordination of mAbs treatment delivery. This highlights the importance of a multidisciplinary approach and SW support in centers providing mAbs therapy.

A256

Use of a proforma to improve the prescribing practices of antipsychotic medications in a community nursing unit in Dublin, Ireland

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Background

Antipsychotic medications (APMs) are associated with significant risks, including falls, sedation, stroke, and death. There is limited evidence of their benefit in management of noncognitive symptoms of dementia (NCSD). Nonpharmacological strategies should be considered first line for management of NCSD. Previous research at our facility (2022) highlighted a high prevalence of psychotropic medication use with suboptimal attempts to deprescribe. A new proforma with prompts was designed to improve prescribing practices highlighting the need for clear indications, regular reviews, and the promotion of nonpharmacological interventions. We aimed to reassess the prevalence of APM prescriptions.

Methods

A cross-sectional analysis was performed on all current residents in our community nursing unit. Data was obtained from medication charts, medical and nursing notes.

Results

A total of 132 patient records were reviewed. 55 patients (42%) were prescribed an APM either regularly (33%) or as needed (PRN, 22%). Only 38% of patients prescribed a PRN APM had received a dose in the preceding three months. PRN psychotropic medications were more likely to be newly prescribed post-admission to residential care than regular psychotropic medications (57% vs 36%). Doctors were significantly less likely to deprescribe medications commenced pre-admission ($I^2=6.2$, $p<0.01$). Risk and benefit discussions were carried out for 63% of residents on a regular antipsychotic, vs 42% on a PRN antipsychotic. There was no documented medication review meeting in over 6 months for 25% of patients on a regular antipsychotic vs 39% on a PRN antipsychotic.

Conclusions

Use of APMs continues to be high in our community nursing unit, despite introduction of the prescribing proforma. Documentation of communication and indication was improved following the introduction of the proforma. Multidisciplinary formal review meetings of prescriptions are now common practice but further research into healthcare professionals' perceived barriers for deprescribing is warranted.

A257

Launching Geriatrics eConsults in academic primary care: A Preliminary Analysis of Early Use

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Introduction: Electronic consultations (eConsults) are increasingly used to deliver timely specialty input and can assist primary care providers (PCPs) in managing complex older adults. This study describes patterns of geriatrics eConsult use after launching a new geriatrics eConsult service in academic primary care.

Methods: We conducted a retrospective chart review of the initial patients (n=10) who received geriatrics eConsults from May to August 2025. Data extracted included patient demographics, primary clinical question, consultation category, and recommended interventions. The most common clinical issues addressed through eConsults, as well as patterns in provider utilization, were described. Interviews were conducted with referring providers on how geriatrics eConsults influenced care management.

Results: All ten eConsults came from academic primary care. Dementia was present in 7 cases, with the remaining 3 cases having suspected cognitive impairment. Primary clinical questions focused on behavioral management (n=5), medication recommendations (n=3), sleep concerns (n=5), and community resource guidance (n=1). Less frequent clinical questions included frailty concerns, cancer screening guidance, and evaluation of pruritus. Recommendations included non-pharmacologic strategies (n=5), medication deprescribing or tapering (n=3), initiation of new medications (n=4), diagnostic workup (n=3), and caregiver or community-resource support (n=6). Interviews indicated that eConsults were sought when providers perceived complexity due to age-related decline, and a combination of behavioral and pharmacological issues. Providers valued consultation responses that guided a stepwise approach to management and offered case-specific education that could be applied to future cases (assessment tools, community resources).

Conclusions: Asynchronous geriatrics eConsults can address a variety of issues in the care of older adults, enhance care coordination, and provide timely geriatric guidance to PCP. Limitations of this work include a small sample size and a single-site design; further research with larger cohorts is needed to better characterize clinical impact.

A258

Boosting Joint Surgery Outcomes with Geriatric Co-Management: A Propensity Score Matched Analysis

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Background: Adoption of best practices, adherence to evidence-based processes, and overall quality of care typically improve with time. The Enhanced Recovery After Surgery (ERAS) pathway and other evidence-based models have added quality to our previously reported elective joints geriatric co-management model (GC) on improved length of stay (LOS) and readmissions. We assessed the continued benefit of GC within the umbrella of ERAS pathway.

Methods: We retrospectively evaluated 7389 patients aged ≥ 65 admitted to the Total Joint Center (TJC) at a teaching hospital for elective joint surgery (07/ 2018- 01/2024) with propensity score (PS) matching to reduce confounding. PS matching accounted for age, race, gender, LACE Index, delirium, abnormal sodium, year of surgery, and AKI within 48 hours after admission. We assessed outcomes, comparing PS-matched cases under GC (1:1 ratio) with controls under

usual care (UC), by multiregression analyses for incident delirium, ICU admission, mortality, and 30-day readmissions. We defined incident delirium as a positive Confusion Assessment Method (CAM) assessment.

Results: Our analytic sample had N=818 matched cases with Standardized Mean Difference (SMD) <0.10 on most characteristics. Mean (SD) age was 77.4 (6.6) years, 67% were female, 91% were white with a BMI of 29.7 (6.4) kg/m², and 82% were admitted from home. Mean LACE index was 7.9 (2.4). GC vs UC group had 99% less incident delirium (0.03 [0.001-0.49]), 89% less hospice or dying in-hospital (0.11 [0.01-0.89]).

Conclusion: We note markedly lower incident delirium and inpatient mortality in those receiving co-managed care. This suggests a continued GC model of care benefit for its recipients, despite uniform application of the ERAS pathway across the TJC program. The retrospective nature of our data limits interpretation of causality, and warrants formal prospective studies to establish effect size, cost benefit, and other outcomes to convince similar joint centers to implement a geriatrics co-management care model.

A259

Too Risky or Not Enough? Optimizing Heart Failure Treatment in a High Risk Elderly Population

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Background: Heart failure (HF) is a leading cause of morbidity among nursing home residents and a key focus for QAPI. Although Guideline Directed Medical Therapy improves outcomes, applying it in elderly residents requires balancing benefit with risks such as hypotension, falls, and hyperkalemia. At the Long Island State Veterans Home (350 beds, 320 residents), we evaluated use and safety of GDMT in a frail, elderly population.

Objective: To identify residents with HF, assess whether they are on appropriate GDMT, and determine which residents are at high risk for GDMT related complications.

Methods: An audit included all LISVH residents labeled with HF and on diuretics. Of 169 initially identified, 103 remained after removing duplicates. Each chart was reviewed for confirmed HF diagnosis (echocardiogram or cardiologist documentation), GDMT use, and high risk features; GFR <35, fall in last year, orthostatic hypotension, alpha agonist use, hospice, or prior hyperkalemia.

Results: Of 103 charts, 25 lacked a documented HF diagnosis; 21 had HFrEF and 57 HFpEF. 27 residents were on beta blockers, 14 on MRAs, 14 on SGLT2i, and 17 on ACEi/ARB/ARNI; none were on all four. Among 78 with confirmed HF, 45 met at least one high risk criterion

Conclusion: Many residents with HF are not on fully optimized GDMT, more than half of those meet high risk criteria. This highlights the need for individualized, risk stratified GDMT and HF specific care pathways in long term care.



A260

Enhancing mentorship skills within a quality improvement curriculum for geriatric and palliative care fellows

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Background

As part of the ACGME milestones for both geriatrics and palliative medicine fellows, all fellows must be able to demonstrate the skills to identify, implement and analyze a QI project as part of system based practice competencies and promote a culture of open communication and effective teamwork within the interdisciplinary team as part of interpersonal and communication skills competencies. Since 2019, 2nd year fellows have participated in a QI leadership curriculum that include a web-based training and Train-the-Trainer Model teaching QI principles and leadership skills. The rationale of this project is to help 2nd year fellows enhance their understanding of quality improvement projects and develop comfort in leading a team with the use of a modified leadership course and a structured leadership feedback tool.

Methods

There was a total of 5 teams. Each QI project included an attending physician and 1-2 second year fellows who lead a team of 4-5 first year fellows. Second year fellows, also known as junior (JR) coaches, were tasked as project managers. All QI coaches participated in a faculty development (FD) curriculum to learn the best strategies to lead QI team projects. Evaluation included a pre-post FD survey comprised of a 6-item questionnaire on comfort with QI concepts using a Likert Scale. Protected teamwork sessions were followed by debriefs using the structured leadership feedback tool reflecting on team dynamics and identifying their stages of team development in reference to the Tuckman's model.

Results

On Pre-FD survey, the average rating for comfort level of teaching QI was 3.2 on the Likert scale. In the first teamwork session debrief, 2 of the 5 groups reported goals were not met due to needing to refine their QI concepts and clarify tasks within their teams. Subsequent teamwork session debriefs revealed that all 5 teams were meeting their goals with 80% functioning in the Norming stage and 20% Performing stage.

Conclusion

Implementing the Tuckman's Model of Team Development as a structured feedback tool for QI teams both guided and organized team-planning and team-leading. Curriculum feedback surveys noted marked improvement in knowledge of most QI domains.

A261

Piloting a Structured Leadership Feedback Tool to Enhance Training of Second-Year geriatric fellows as QI Coach Leaders

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Background

Leadership requires training. Since 2019, 2nd year fellows participate in a QI leadership curriculum for coaches consisting of A. asynchronous web-based training to reinforce understanding of QI principles and B. Train-the-Trainer Model to teach group facilitation techniques. Although 2nd year fellows were able to demonstrate improved QI knowledge (QI Knowledge Application Tool 22.4-->24, $p=0.001$) and comfort with QI concepts (use of process maps, fishbone diagrams, PDSA model for improvement, $p<0.01$), 2nd year fellow did not show increase in confidence in their role as Junior QI coaches (Pre 3.27, Post 3.63, $p=0.37$; Likert Scale 5= Very Comfortable, 1= Very Uncomfortable). Qualitative feedback from Junior QI coaches described challenges such as keeping fellow interest, participation and keeping QI team on track. To address this gap, we created and piloted a Structured Leadership Feedback Tool for Junior coaches to strengthen their coaching and leadership skills.

Methods

We developed a Structured Leadership Feedback Tool SLFT that faculty coaches used to plan and debrief Junior coach leadership skills after a teamwork session. SLFT consists of 5 questions to help plan the team work session and included Tuckman's model for team development to trouble shoot team dynamic issues. Evaluation of the SLFT consists of a prospective 8 question survey completed by all coaches to assess junior coach comfort with common leadership duties as well as rate how helpful the SLFT was.

Results

Five dyads of 2nd year fellows and faculty coaches utilized the SLFT on 2/27/25. Junior coaches rated SLFT 4.6 in terms of helpfulness as it provided a structured framework to plan and guide team work sessions and encouraged faculty and Junior coaches to trouble shoot anticipated team dynamic barriers. After SLFT pilot, Junior coaches reported improved comfort coaching (pre 3.6; post 3.8; $p=0.36$) though comfort remained <4 for motivating (3.2), delegating (3.8), keeping on task (3.4), and giving feedback (3.4).

Conclusion

Use of the Structured Leadership Feedback Tool may help enhance training of 2nd year fellows as QI coach leaders. Next steps include piloting the SLFT earlier in the academic year and providing more guidance on practical application of Tuckman's model of team development.

A262

Educating Patients on Upcoming Skilled Nursing Facility Stays

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Background: Acute hospitalization can be very stressful for patients, and transition to a next level of care, such as a Skilled Nursing Facility (SNF), can also be anxiety-provoking. Patients are often presented with information about SNFs that is hard to absorb or inaccurate, which can lead to unmet expectations and poor perceptions of SNF care. We present a quality improvement (QI) project that provides hospitalized patients and/or their support system with an educational handout about SNF services prior to transfer. Our primary aim is to improve patients' understanding and satisfaction with their SNF experience. Secondly, we hope improved satisfaction will lead to better outcomes, such as decreased length of stay and fewer hospital readmissions.

Methods: An educational handout was developed using input from SNF staff regarding common patient misconceptions and complaints. Patients were then administered a pre- and post-pamphlet quiz to test their knowledge. Surrogates were given the quiz if patients were not able to participate due to cognitive impairment. Patients with limited English proficiency were excluded from the study. In our upcoming PDSA cycle, we plan to pair the handout with a brief physician counseling session and evaluate satisfaction among patients who did and did not receive the intervention using a short survey administered prior to SNF discharge.

Results: A total of 29 patients were offered the educational intervention. 9 of the 29 agreed to participate. Only 6 of these 9 completed both pre- and post-handout assessments. Of these respondents, 66% showed improved knowledge after reviewing the handout, while the remainder showed no change. Qualitatively, patients reported positive sentiments about the helpfulness of the educational handout.

Conclusion: Patients transitioning to SNF from the inpatient setting may not have accurate expectations of SNF due to incomplete information or stress that is commonly experienced during this time. A simple educational handout, designed based on misconceptions of patients as observed by SNF staff, can increase their knowledge about SNF services and improve their experience. However, there may be hesitancy in accepting the information when tied to knowledge assessments. We hypothesize that combining the handout with a physician counseling session will improve engagement, satisfaction, and outcomes such as length of stay and hospital readmissions.

A263

The Use of GeneSight Psychotropic Testing in the Management of Major Depressive Disorder in Elders: A Detour in Depression Treatment

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Background: Major depressive disorder is an important diagnosis, particularly in elders who can present atypically compared to the general population. First-line class of anti-depressants can take 6-8 weeks or longer to take effect, and in many instances may not be efficacious in treating elders with moderate to severe depression. We used the PHQ-2 scale to screen for depression and measure the change in scores after adjusting medications based on GeneSight psychotropic testing. We hypothesized that PHQ-2 scores would decrease after 8-12 weeks of treatment with antidepressant medications based on individual GeneSight psychotropic testing.

Methods: For this prospective cohort study, we included community dwellers living in the state of South Carolina with the diagnosis of major depressive disorder. These patients were treated for depression with antidepressant medications between November 2024 and November 2025 in an ambulatory setting. We adjusted antidepressant medication using individual GeneSight psychotropic testing and measured the change in PHQ-2 scores over 8-12 weeks for patients

who failed at least one first-line antidepressant medication prior to GeneSight testing.

Results: This study included 20 community dwellers with a mean age of 76.1, 75% (n = 15) female, and 10% (n = 2) were persons who identified as underrepresented sexual orientations. Among the 25 patients who underwent GeneSight testing, 75% of individual PHQ-2 score decreased over 8-12 weeks after medication adjustments were made using the GeneSight testing.

Conclusion: We found that community dwellers who underwent GeneSight testing had decreased PHQ-2 results after 8-12 weeks follow up for major depressive disorder. GeneSight psychotropic testing can offer a patient-centered approach in the management of major depressive disorder in elders. One limitation of this study is the small sample size and the restriction to the ambulatory setting. Further investigation is needed to explore the impact of GeneSight psychotropic testing in other clinical settings as well such as subacute rehabilitation and long-term care centers.

A264 Encore Presentation

Overutilization of glycohemoglobin testing in Long-Term Care Facility.

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Background: Diabetes affects over 11% of the U.S. population, with prevalence rising to 29% among individuals aged 65 and older. Glycohemoglobin (A1c) is a critical marker for diabetes management, reflecting average blood glucose control over approximately 90 days—the lifespan of red blood cells. This physiological timeframe limits the clinical utility of testing to once every three months.

Methods: We analyzed 40,542 A1c specimens collected from long-term care facility residents between January and September 2025. Results were stratified by gender and age, with a 90-day interval used as the threshold for appropriate test reordering. Statistical analyses were performed using Analyse-it software.

Results: Women comprised 54.4% of specimens tested. Notably, 32.7% of samples had no previous A1c results on record, while 14.3% were reordered within less than 90 days of the prior test.

Conclusion: Our data reveal that A1c testing is ordered more frequently than clinically indicated, contributing to unnecessary healthcare expenditures. This overutilization contradicts evidence-based guidelines, including recommendations from the Choosing Wisely Campaign, and carries both clinical and economic consequences. Comprehensive test utilization stewardship programs are needed, incorporating physician education on appropriate testing intervals, audit and feedback systems, and clinical decision support integrated into electronic ordering platforms.

Table 1

	Female	Male	Total
No Previous Results	32.5%	32.8%	32.7%
<90 Days interval	13.6%	15.1%	14.3%
≥90 Days interval	53.9%	52.2%	53.1%

A265

Closing the Gap in Goals of Care Conversations for Patients with Moderate to Advanced Dementia in a PACE Program – A Quality Improvement Project

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Background – Approximately 14 million people will suffer with dementia in the United States by 2060. The complexity of care for patients with dementia intensifies at the end of life. Advance care planning (ACP) is a process that helps clarify an individual's values, goals, and preferences regarding future medical care. There are several factors that contribute to poor ACP. These barriers include inconsistent participation in ACP conversations during the early stages

of dementia, variable documentation by clinicians, and residence in nursing home facilities. The objective of this QI project is to identify patients with moderate to advanced dementia enrolled in a PACE program, with and without documented GOC conversations and evaluate the impact of implementing a GOC conversation protocol.

Methods – A comprehensive chart review is being performed to identify adults aged ≥65 with a documented diagnosis of moderate to severe dementia, based on clinical assessments, cognitive testing, functional staging, or provider documentation. For each participant identified with moderate to severe dementia, a subsequent review will be completed to determine if an ACP has been documented within the last 12 months. Baseline data will include dementia severity, decision maker documentation, code status, and presence of advance directives or POLST forms. Next, participants without documented GOC conversations will be flagged for a structured GOC discussion conducted with the patient (if possible) and their caregiver or surrogate decision maker. Conversations will follow the Serious Illness Conversation Guide. A standardized EMR template will be used to document key elements of each conversation.

Results – Primary outcome will be identifying percentage of PACE participants with moderate to severe dementia who have documented ACP. Secondary outcome will be a change in proportion of participants with documented ACP after implementing a targeted GOC conversation. Future goals will be to develop a sustainable strategy to ensure participants in a PACE program with moderate to severe dementia will be prompted to have an ACP conversation at enrollment.

A266

Utilizing the Readmission Risk Score (RRS), the Carey 3 year Mortality Index (CYMI) and the Serious Illness Conversation Guide (SICG), to improve communication of prognosis and documentation of “What Matters Most”: The qualitative findings of a QI project.

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Background: Admission to a PACE often marks a major milestone for many older adults as their frailty and co-morbidity advance over time. Patients at the highest risk of hospitalization and death are likely to benefit the most from a discussion of prognosis and to reflect and document “What Matters Most” to them as their health changes. Tools such as the RRS and CYMI are validated tools that can help better estimate prognosis among patients.

Methods: We used the RRS on EPIC to stratify patients according to their risk of hospitalization. Patients in the highest quartile of RRS were reviewed with their individual PCPs for their suitability to participate in the project. Patients were excluded if they lacked capacity for advanced care planning and did not have a healthcare proxy (HCP), or their HCP was not available, or for any other reason that their PCP felt was relevant. A total of 17 patients participated in the project across 2 PACE sites.

While respecting an older adult's right not to know their prognosis through focused questions at the outset of how much information they wished to know, we engaged with them or health care proxies identified. This occurred in the form of a face-to-face or telephone encounters. The individual CYMI risk was disclosed, followed by the administration of a modified SICG.

Results: We found that 47% of patients or healthcare proxies had not had a discussion of their overall prognosis or life expectancy, 41% did and 12% were unable to recall. All but one these patients and/or healthcare proxies wanted to have discussions about prognosis, and expressed a high degree of comfort with the topic. All of the participants wished to continue longevity focused care including those who wished to be DNR. A sizable proportion of patients had not discussed their treatment preferences with their HCPs. None of the patients had documented SICGs completed in line with current levels of provider awareness.

Conclusions: Bringing advanced care planning in to QI space can be difficult. Systematic identification of high-risk patients, effective communication of prognosis, and completion of structured SIGCs may provide a framework for doing so. These findings will be disseminated to the provider group with follow up later this year.

A267

Impact of Admission Documentation Practices on Pressure Injury Rates in a Skilled Nursing Facility

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Background:

Pressure injuries are a significant cause of morbidity and reduced quality of life among older adults in nursing homes and are associated with increased risk of infection, hospitalizations, and mortality. They also contribute to higher healthcare costs and negatively impact publicly reported facility quality metrics. Accurate identification and reporting of baseline pressure injuries at admission are necessary to distinguish pre-existing injuries from those acquired during a skilled nursing facility stay. Incomplete or inconsistent documentation may lead to underrecognition of existing pressure injuries, delayed interventions, and inflated rates of facility-acquired pressure injuries. We hypothesize that inadequate documentation of pressure injuries on admission contributes to inaccurate reporting and higher pressure injury rates at a skilled nursing facility. Our goal is to reduce the percentage of patients with new or worsening pressure injuries by improving admission documentation practices.

Methods:

Structured interviews with nursing and wound care staff were conducted to map the current state of the wound assessment and documentation workflows in a skilled nursing facility. This process map was used to identify the root causes of inaccurate skin assessments and of pressure injury documentation at admission. Based on these findings, targeted countermeasures were selected and are currently being implemented.

Results: Results are pending.

Conclusions:

Continued monitoring will determine whether the selected interventions improve documentation accuracy and reduce facility-reported pressure injury rates. The findings will inform future interventions and quality improvement efforts to improve geriatric care in skilled nursing facility settings. We will also establish processes to maintain the progress made.

A268

Enhancing Delirium Coding and Geriatric Referral Pattern in Older Adults: A Hospital-Wide Quality Improvement Initiative

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Background: Delirium is common but underdiagnosed and approximately 45% may persist at time of discharge. Without pathway of follow-up, it leads to missed opportunities for timely treatment. At our large tertiary-care academic medical center, referrals to the post hospital discharge Geriatrics Delirium Clinic remain low relative to the expected burden of delirium experienced by acutely ill hospitalized adults aged ≥ 65 . The objective of this project is to increase delirium detection through improved ICD-10 coding and documentation and to increase appropriate referrals to the geriatrics inpatient service and post discharge Geriatrics Delirium Clinic.

Methods: To better understand the scope of the problem we plan to analyze Electronic Medical Record (EMR) documentation of delirium through utilization of delirium-related ICD-10 codes in

hospital wide documentation compared to geriatricians led documentation from June to December 2025. Keyword triggers include “confusion,” “altered mental status,” “agitation,” and “encephalopathy”. We will compare the code utilization in the general patient population and the population ≥ 65 years; coding patterns by hospitalists, surgeons, and geriatricians; proportion of coded patients receiving geriatric consultation; time from coding to consultation; appearance of delirium-related terms in discharge summaries; and demographic characteristics (age, gender, race/ethnicity). We will utilize descriptive statistics and conduct fish bone analysis to determine opportunities and challenges to improve diagnosis and documentation.

Results: In a 6 month period we will analyze the number of delirium-related ICD-10 codes utilized hospital-wide compared to geriatrician-led documentation. We also analyze how many probable delirium cases did not receive geriatric consultation and define potential opportunities and challenges to improve referral pathways to the inpatient geriatrics service and post hospital discharge Geriatrics Delirium Clinic.

Conclusions: A system-wide EMR analysis of the patterns of delirium documentation in a large tertiary-care academic center appears effective to understand patterns of delirium diagnosis and define challenges and opportunities leading to improved delirium prevention and care through downstream referral to specialized delirium care.

A269

Motivating Movement: Clinician-Reported Barriers to Physical Activity Counseling

V. Jain,² J. Lee,¹ C. Rovzar,¹ S. Tee,¹ 1. *Stanford, Palo Alto, CA*; 2. *Geriatrics, Stanford, Palo Alto, CA*.

Background: The benefits of physical activity in older adults are well documented for both physical and mental health. However, only about 13.9% of adults 65 years and older meet the national physical activity guidelines of 150 minutes of moderate exercise weekly. Surveys have found that older adults are not regularly counseled on physical activity, particularly in a preventative manner. The aim of this quality improvement study is to assess current practices and barriers to counseling for geriatricians to inform future tailored interventions. **Methods:** An anonymous 11-item survey was developed to assess confidence, frequency of counseling, and possible barriers to physical activity counseling. The survey items included Likert scales, multiple choice questions, and free-responses. It was distributed electronically to twelve geriatrics clinicians at a large academic center. **Results:** Eleven out of twelve surveys were completed ($n = 11$; 92% response rate). Most clinicians (10/11; 91%) felt confident providing physical activity counseling to older patients, rating themselves ≥ 3 on the Likert scale of 1 (least confident) to 5 (most confident). Only 3/11 (27%) clinicians reported counseling on physical activity during their last annual wellness visit. All clinicians reported counseling patients at least “Occasionally,” with 9/11 (82%) responders counseling “Often” or “Always.” Reported counseling time for all was ten minutes or less. Most clinicians reported counseling on strength-training (9/11; 82%), balance (9/11; 82%), aerobics (8/11; 73%). No physicians reported counseling on flexibility. The primary barriers identified were “Lack of time” and “Lack of training” (7/11; 64% selected both). Ten clinicians (10/11; 91%) expressed interest in additional resources, particularly pre-populated electronic health record (EHR) clinical templates or patient handouts. **Conclusions:** Clinicians reported high confidence levels in counseling but lower rates of actually doing so during their last wellness visit due to lack of time and training. They reported counseling in all domains except flexibility, which has limited evidence and no proven benefit. Resources such as pre-populated EHR templates and patient-education handouts with lists of exercises could address barriers in timing and training. Future interventions will involve creation of EHR clinical templates for providers, patient-education handouts, and brief didactic for clinicians.

A270

Assessment of Current Practices and Perceived Barriers for Professional Interpreter Use in Skilled Nursing Facilities

Y. Rosli, S. Rajagopal, G. Kim, M. Wang. *Gerontology and Geriatric Medicine, University of Washington, Seattle, WA.*

BACKGROUND:

Patients who use a language other than English (LOE) often experience barriers in accessing care and communication breakdown resulting in poor health outcomes¹. In low resource settings such as skilled nursing facilities (SNF), the availability of professional interpreter services (PIS) compared to other clinical environments is limited. We aim to assess barriers to access and use of PIS in SNFs and identify areas for intervention.

METHODS:

SNF staff and administrative leadership completed surveys via REDCap at three SNFs in Seattle from June 1 to November 14, 2025, with data collection ongoing. The staff survey assessed prior training with PIS and frequency of PIS utilization in various patient interactions such as admissions, routine care, changes in clinical status, and dispositions, while the administrative leadership survey considered resources and funding for PIS and staff training. Both surveys evaluated the type of resources available for interpretation, barriers to PIS use, and perceptions of potential benefits of PIS use.

RESULTS:

We analyzed 43 responses from staff and 6 responses from administrative leadership. The majority (58.1% of staff) reported that they did not receive formal training in PIS use. Variable PIS use was reported in multiple settings: admission (42.9%), routine care (27.8%), acute change in status (39.5%), follow-up therapy session (7.7%), and disposition (42.9%). Most perceived barriers to PIS use include: resident factors (64.3%) and difficulty to access PIS (50%). 54.8% respondents believe that language barriers contribute to lower quality of care and 61.9% agree that there is a great need in improving the quality of communication for patients who use LOE.

CONCLUSIONS:

In this study, most SNF staff reported that they did not receive formal training in PIS use. Respondents described frequent informal interpreter use in complex transition-of-care, such as admission and disposition planning. Next steps involve developing an intervention to increase formal training in PIS use for SNF staff, highlighting the importance of its use for transitions-of-care, and assessing the feasibility of a handheld translation device for routine brief interactions as a harm reduction model.

REFERENCE:

¹Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care.* 2007 Apr;19(2):60-7.

A271

Standardizing Documentation of Advance Care Planning Discussions in an Academic Geriatrics Practice Across Multiple Service Lines

Y. Geniza,² D. Orias,² G. Sandhu,² A. Wen,^{2,1} C. Takenaka,^{2,1} J. Moore,^{2,1} P. Lee,^{2,1} K. Masaki.^{2,1} 1. *Queen's University Medical Group, Honolulu, HI;* 2. *Department of Geriatric Medicine, John A. Burns School of Medicine, University of Hawaii, Honolulu, HI.*

Introduction: Advance care planning (ACP) is a vital part of geriatric care, helping patients reflect on serious illness, clarify care values, and identify preferences for future treatment. Despite this, ACP remains underused, and difficulty locating documentation of most recent ACP discussions in the EMR is one such barrier. Our quality improvement project aimed to improve the consistency of documenting ACP discussions in the EMR.

Methods: Physicians (n=24), nurse practitioners (n=16) and geriatrics fellows (3) in an academic geriatrics practice (clinic, HBPC,

inpatient consults, and PALTC) participated (total N=43). Phase 1 was a needs assessment survey (Pre-survey), asking where clinicians place and find ACP discussion information in EPIC. Phase 2 was an educational intervention about documenting ACP discussions in the Care Coordination tab in EPIC (conducted in September 2025). Phase 3 was a Post-survey assessing efficacy of the education. We used descriptive statistics and paired t-tests to compare pre- and post-survey scores for ACP accessibility, satisfaction, and ease of documentation (Likert scale 1-5).

Results: Mean scores improved after the educational intervention for satisfaction with ACP discussion documentation (3.4 vs 3.9, p=0.008), ease of documentation (3.6 vs 4.0, p=0.006), and ease of finding most up-to-date ACP discussions in EPIC (3.0 vs 3.8, p<0.0001). Knowledge of how to access the EPIC Care Coordination tab rose from 46.5% to 88.4%, with use of Care Coordination note increasing from 23.3% to 48.8%; 74.4% reported following the new protocol. "Not enough time" and "too many steps" remained the top reported barriers, but the number reporting "no clarity about process" decreased from 17 to 9.

Conclusion: Previously, we addressed standardization of uploading ACP directives and POLST into the EMR. However, end of life wishes are subject to change along the course of a patient's health status and therefore ACP discussions are best revisited routinely and during acute changes to a patient's medical condition. We standardized the documentation of ACP discussions in the EMR to improve accessibility across various health service lines within an academic geriatrics practice, resulting in improved provider satisfaction.

PRESIDENTIAL POSTER SESSION B

Thursday, April 30

5:00 pm – 6:00 pm

B1

Assumptions That Harm: Under-Recognition of HIV in Older Adults

A. Nizinski. *University of Rochester Medical Center, Rochester, NY.*

INTRODUCTION: Individuals aged ≥ 50 account for approximately 20% of new HIV diagnoses, however, the risk of infection is often under-recognized or overlooked in the geriatric population¹. Limited provider awareness constitutes a critical barrier to HIV detection in older adults, and age-related stigma can preclude the elicitation of a complete sexual history and skew the perceived need to perform HIV testing.

CASE: A 76-year-old community-dwelling, cisgender gay male presented to the ED with severe acute perianal pain, found to have a large linear macerated ulcer within the gluteal cleft. This lesion was positive for herpes simplex virus and treated with valacyclovir. Review of systems was notable for months of unintentional weight loss, fatigue, and subacute night sweats. Previous workup had revealed diffuse lymphadenopathy incidentally found on CT three years prior and persistent leukopenia dating back six years. A detailed sexual history was later obtained during his hospitalization and HIV testing was ordered, which hadn't been performed in eight years. The patient was ultimately found positive for HIV and was promptly started on antiretroviral therapy (ART) with subsequent weight gain, improvement in energy levels, and resolution of his night sweats.

DISCUSSION: The misconception that older adults are not sexually active nor engage in high risk behaviors that may predispose them to HIV is pervasive among healthcare providers and society at large. This falsehood is one of several postulated reasons why studies have frequently found that older adults are more likely to be diagnosed with HIV at a later stage of disease than their younger counterparts, which can lead to worse health outcomes and response to ART^{1,2}.

The patient highlighted in this case had multiple clinical features consistent with HIV, yet he went undiagnosed for many years. It is imperative that clinicians heighten their awareness for HIV in older adults and broaden their testing efforts in this population.

REFERENCES:

¹ Ellman, TM, Sexton, ME, Warshafsky, D, et al. A forgotten population: older adults with newly diagnosed HIV. *AIDS Patient Care and STDs*. 2014;28(10):530-536.

² Wang, Z, Patterson, W, Rajulu, D. Aging with HIV: an epidemiological profile of persons with diagnosed HIV aged 50 years and older in New York State, 2012-2021. *Journal of Acquired Immune Deficiency Syndrome*. 2024;97(4):353-356.

B2

Ramelteon for Delirium Prevention in Older Adults Hospitalized After Hip Fracture: A Retrospective Case Series

E. R. Thompson Westermeyer,¹ A. Anyim,² S. Keller,² A. K. Palmer.²
1. Medicine, University of Minnesota, Edina, MN; 2. Hospital Internal Medicine, Mayo Clinic, Rochester, MN.

Intro: Delirium is a serious complication that occurs commonly among hospitalized older adults and has a higher prevalence in patients with cognitive impairment or dementia. Ramelteon, a melatonin receptor agonist, has been shown to have potential in delirium prevention, though results have been mixed. We conducted a large retrospective case series evaluating the role of ramelteon in preventing delirium in older adults hospitalized after hip fracture.

Methods: We reviewed 211 patients hospitalized with hip fractures at a single institution between 2015 and 2021. Baseline characteristics included age, sex, pre-existing cognitive impairment, and pre-hospital living situation. Patients with evidence of delirium on presentation were excluded. Primary outcomes included incident delirium, which was ascertained using a modified CHART-DEL methodology, and length of stay (LOS). Patients who received ramelteon, prescribed by a hospitalist group focused on delirium prevention, were compared with patients treated by a different group that did not routinely prescribe ramelteon.

Results: Of 159 patients included, 30 were treated with ramelteon. Patients treated with ramelteon were older (85.6 vs. 81.2 years old, $p < 0.05$) and had a higher rate of baseline cognitive impairment (80% vs. 37%, $p < 0.05$). Timing of ramelteon administration varied. Patients treated with ramelteon experienced a higher rate of delirium (63% vs. 30%). There was no difference in LOS. In patients with baseline cognitive impairment, definite delirium did not differ between groups (46% vs. 41%, $p = 0.61$).

Discussion: Our data demonstrate no significant difference in incidence of delirium in hospitalized older adults treated with ramelteon. These findings are limited by the nonrandomized allocation of groups with significant baseline differences. The ramelteon group had significantly higher rates of cognitive impairment, a delirium risk factor, which likely influenced prescribing decisions and contributed to the observed higher delirium incidence. The variable timing of administration of ramelteon further limits assessments of its effectiveness as a prophylactic strategy.

Despite these limitations, our findings contribute meaningful observational evidence regarding the limited utility of ramelteon in delirium prevention. Further work could assess its impact on delirium severity.

B3

Beyond Frailty: a Case Series Proposing a Dual-Dimension Model Integrating Resilience for Older Adult Phenotyping

A. Sawicki,¹ A. Orkaby,¹ J. Bean,¹ A. Schwartz.² 1. New England GRECC, Veterans Affairs Health Administration, Brookline, MA; 2. GRECC, VA Boston/Harvard Medical School, Boston, MA.

Background: Both frailty and resilience attempt to encompass the ability of the human body to maintain homeostasis, as multidimensional frameworks for assessing older adults. Frailty represents the cumulative effect of multiple variables to diminish physiological reserve. Resilience is thought of as the individual's capacity to maintain adequate function and structure after being subjected to specific stressors. Frailty is increasingly used for prognostication and decision-making tool, while resilience has not yet been operationalized in the same way.

Methods: A case series of patients with varying levels of frailty and resilience representing archetypal phenotypes of older adults.

Case Descriptions: Case 1 (low frailty-high resilience): 80 y/o man seen in geriatric clinic. Pre-frail CGAFI-0.15. Self-referred due to subjective cognitive decline, cognitive screeners with mild impairment but stable for the past 2 years, life history of dyslexia. Avid runner all his life, still robust on exam with normal gait. During clinic interested in learning about Erikson's theory of transcendence between different stages in life. Case 2 (high frailty-high resilience): 103 y/o man WW2 veteran seen in a home-based primary care visit. Severe frailty CGAFI > 0.45 for at least 5 years prior, driven by comorbidities. High social support, financial stability, strong cognitive baseline. When asked what his secret to life is, reports "love". Case 3 (low frailty-low resilience): 78 y/o man, pre-frail CGAFI-0.12, evaluated by the geriatric oncology clinic. Estranged from family, history of MDD with hospitalizations. Seen on palliative service with terminal delirium vs. MDD after not recovering from surgery. Case 4 (high frailty-low resilience): 81 y/o man, Vietnam veteran, severely frail CGAFI > 0.45, driven by comorbidities, mobility (wheelchair dependent), nutritional status, Alcohol Use Disorder and psychiatric conditions. Homeless, followed by appropriate services.

Discussion: This case series illustrates a 2X2 framework of understanding the relationship between frailty and resilience as two separate and complimentary dimensions to apply toward phenotypical understanding of older adults. With further study, this approach may contribute to operationalizing resilience research to be translated to clinical applicability, alongside frailty.

B4

Restoring the Senses to Restore the Mind

A. Nguyen, M. Bogin. *Community Internal Medicine, Mayo Clinic, Rochester, MN.*

Background: Delirium is common in hospitalized older adults. Sensory impairments contributing to delirium in the hospitalized patient can hinder meaningful recovery, potentially resulting in interventions that do not align with patient's preferences.

Case Description: An 85-year-old man was admitted to the hospital from a skilled nursing facility with dementia and recurrent falls. At baseline, he was independent with most ADLs other than bathing and he ambulated with a walker. Family was not present locally. His hospitalization was complicated by ICU admission, intubation, multiple transfusions, and vasopressor support, with large ulcer found on EGD without acute bleeding. He remained NPO for a prolonged period for procedures for workup of gastrointestinal bleeding and was deemed to have malnutrition. Hospitalization was further complicated by challenges in communication in the setting of presumed hospital acquired delirium. He struggled to participate meaningfully in skilled therapies. An NG tube was placed for nutrition, and goals of care discussions ensued regarding long-term nutrition with PEG feeding, though prior advanced directives suggested this was not in line with his long-term

goals. After family arrived at the hospital, it was revealed to the medical team that the patient was profoundly hearing impaired, which was not known when he was admitted. He was fitted with hearing aids and amplifiers and the staff was educated on effective communication methods with him, with significant improvement in his mentation. Diet was advanced through better participation with speech therapy, and a PEG tube was avoided. He was eventually dismissed back to his home facility.

Conclusion: This case illustrates the importance of addressing sensory impairments which are modifiable contributors to delirium. Early sensory assessment and use of appropriate aids can meaningfully alter hospital trajectory and improve patient participation in care.

B5 Student Presentation

“My Brain Is Back”: The Disguised Adenoma—Reversible Dementia in Normocalcemic Primary Hyperparathyroidism

A. J. Laico,¹ A. Rotkiewicz-piorun.² *1. John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX; 2. Division of Geriatric Medicine, Department of Internal Medicine, University of Texas Medical Branch, Galveston, TX.*

Background:

Primary hyperparathyroidism (PHPT) is common in older women, with prevalence rising to 2–3% after age 70. Hypercalcemia and elevated PTH may cause cognitive decline, yet PHPT can be overlooked when calcium fluctuates or is masked by CKD, vitamin D deficiency, or cinacalcet. We report an 87-year-old woman with rapidly progressive cognitive impairment initially attributed to dementia and depression, whose symptoms proved reversible after surgical treatment of PHPT.

Methods:

This case is based on laboratory, imaging, and cognitive data from geriatric clinic, emergency department, and inpatient encounters between 2022 and 2024. MRI showed advanced microvascular ischemic changes but insufficient to explain rapid decline. Vitamin D replacement (25-OH vitamin D rising from 21 to >60 ng/mL) unmasked hypercalcemia and PHPT.

Results:

The patient presented with rapid memory loss and confusion (SLUMS 16/30, down from 30/30 3 years earlier). Initial findings included CKD 3a (eGFR 46), borderline normocalcemia (10.6 mg/dL), and vitamin D deficiency (25-OH vitamin D: 21 ng/mL). Over the next year, calcium fluctuated (10.1–12.2 mg/dL) while CKD worsened (eGFR 29), PTH was 424 pg/mL. Despite presumed secondary hyperparathyroidism, ionized calcium—measured later—remained persistently elevated (5.9–6.0 mg/dL). Cognitive decline had progressed despite memantine and psychosocial support. Early endocrine evaluation emphasized 1,25-OH vitamin D rather than ionized calcium or early imaging, delaying recognition of PHPT.

A sestamibi SPECT/CT in 2024 revealed an ectopic retrosternal parathyroid adenoma. She underwent inferior parathyroidectomy, complicated by postoperative hypocalcemia consistent with hungry bone syndrome. Within four weeks, cognition improved dramatically (“my brain is back”), with SLUMS rising to 24/30 and MMSE reaching 29/30 at one year.

Conclusions:

This case highlights how PHPT may mimic dementia in older adults, particularly when hypercalcemia is intermittent or obscured by CKD or vitamin D deficiency. PTH excess can impair cognition independent of calcium level. Prompt measurement of ionized calcium and PTH in older adults with unexplained cognitive decline is essential, as timely identification and treatment of PHPT can reveal a highly reversible form of dementia.

B6

Using Plasma Biomarkers to Differentiate HIV-Associated Neurocognitive Disorder from Other Dementias

B. M. Gonzalez Morales, F. Kobylarz. *Family Medicine and Community Health, Rutgers RWJMS, New Brunswick, NJ.*

BACKGROUND: Older adults now represent more than half of the people living with HIV in the US. Cognitive decline may be an initial presentation of HIV infection when traditional risk factors are absent. Although ART suppresses viral replication, many patients continue to experience HIV-associated neurocognitive disorders (HAND), which may resemble Alzheimer’s disease (AD) or vascular dementia (VD). Distinguishing these conditions is challenging. Emerging plasma biomarkers, including p-tau217, offer a noninvasive tool to improve diagnostic accuracy when clinical features overlap.

CASE: An 82-year-old Hispanic male with HTN, CAD, and Depression presented with a 3-year history of progressive memory loss, word-finding difficulty, anxiety, and recent auditory hallucinations. Functional decline worsened after his wife’s death 7 months ago. Symptoms began before his HIV diagnosis in January 2024. He denied sexual activity, injection drug use, or transfusions; a remote needlestick exposure in Ecuador was considered possible. MoCA score 21/30 with deficits in visuospatial skills, language, and orientation. GDS 6/15 and treated for depression with SSRI. Initial HIV-1 RNA was 2,200,000 copies/mL, later becoming undetectable on ART; CD4 count improved from 247 to 323 cells/mm. B12, folate, TSH, hepatitis panel, and RPR were normal. MRI showed mild-moderate small-vessel ischemic disease. Plasma p-tau217 measured 0.14 pg/ml below established AD thresholds.

DISCUSSION: Up to 45% of people with HIV experience neurocognitive impairment despite viral suppression. HAND symptoms—including deficits in executive function and memory—can mimic early AD. In this older adult with vascular risk factors and an atypical exposure history, determining the cause of cognitive decline was challenging. A low p-tau217 level significantly reduced the likelihood of AD. Plasma biomarkers may help avoid invasive CSF testing and clarify diagnosis when neuroimaging is nonspecific. This case also highlights the need to consider HIV testing in older adults with unexplained cognitive decline.

CONCLUSION: HIV should remain part of the differential diagnosis in older adults presenting with cognitive impairment. Plasma p-tau217 provided diagnostic clarity by lowering the likelihood of AD and supporting a diagnosis of HAND and VD. Incorporating plasma biomarkers may improve diagnostic precision and guide management in aging adults with HIV.

B7 Student Presentation

When Bone Loss Tells the Story: A Case of Celiac Disease Identified Through Osteoporosis Evaluation

B. Bennett,^{1,2} J. Gomes.^{1,2} *1. University of Louisville School of Medicine, Louisville, KY; 2. University of Louisville Health, Louisville, KY.*

Background:

Osteoporosis leading to fragility fractures is a major cause of morbidity worldwide. Secondary causes of low bone mineral density (BMD) are often overlooked, especially in postmenopausal women, despite their impact on treatment response. Celiac disease is an autoimmune disorder that commonly presents with gastrointestinal symptoms but may instead present with atypical, non-gastrointestinal manifestations, including low BMD.

Case:

An 83-year-old woman with hypertension, hypothyroidism, and hyperlipidemia had progressive BMD decline on DEXA despite bisphosphonates. From 2023 to 2025, lumbar spine BMD decreased from 0.831 to 0.794 g/cm², left femoral neck from 0.677 to 0.668 g/cm², and right femoral neck from 0.713 to 0.655 g/cm². She had no history

of smoking, alcohol use, renal disease, low body weight, or known celiac disease. Medications included calcium, vitamin D, levothyroxine, benazepril, pravastatin, amlodipine, and alendronate.

Labs showed low-normal calcium (8.4 mg/dL), elevated alkaline phosphatase (126 IU/L), vitamin D deficiency (16 ng/mL), elevated PTH (98 pg/mL), and positive celiac serologies: endomysial IgA (1:80), tTG IgA (> 250), deamidated gliadin IgG (87.4), IgA (>250). She recalled six months of softer stools. A gluten-free diet improved symptoms, and small-bowel biopsy confirmed celiac disease. She was treated with a gluten-free diet, high-dose vitamin D, and calcium supplementation before resuming osteoporosis therapy.

Discussion:

Declining BMD during bisphosphonate therapy should prompt evaluation for secondary causes of osteoporosis. More than half of patients with celiac disease present without classic GI symptoms and may present with metabolic bone disease. Bone loss mechanisms in celiac disease include secondary hyperparathyroidism from calcium and vitamin D malabsorption, cytokine effects, and increased bone turnover. Hypocalcemia or elevated alkaline phosphatase despite supplementation should raise suspicion for malabsorption.

Conclusion:

Osteoporosis may be the presenting manifestation of undiagnosed celiac disease in older adults. Untreated celiac disease can blunt the response to osteoporosis therapy. Therefore, clinicians should consider evaluating adults with worsening osteoporosis despite therapy for possible celiac disease, as identification and treatment with a gluten-free diet and nutrient repletion can improve bone health.

B8 Resident Presentation

From a red herring to a red joint: not all AMS is UTI-induced

C. Ochoa Farho. University of Nebraska Medical Center, Omaha, NE.

Background: This case highlights the pitfalls of overtreating presumed UTIs in older adults with altered mental status.

Case: An 81 year old male with a past medical history including CKD, metastatic prostate cancer, and prosthetic knee replacement presented to the emergency department (ED) after he became confused, slid out of his recliner, and was unable to get up.

Further questioning revealed he had been nauseous for the past few days with increasing weakness. He endorsed urinary incontinence secondary to inability to make it to the bathroom. He denied hematuria, dysuria, flank pain, or fevers. He endorsed severe pain in his joints: specifically left wrist, right shoulder, and right knee. Work up in the ED was negative for fever, tachycardia, or hypoxia. Labs showed a white count of 18. No acute abnormalities of spine or chest/abdomen on CT. X-rays performed of his bothersome joints demonstrated no evidence of fracture or trauma.

Urinalysis (UA) obtained showed positive nitrites, small leukocyte esterase, and pyuria. The ED requested admission for treatment of UTI and AMS/weakness. Joint pain was attributed to overexertion in trying to get himself up off the ground.

Physical exam performed by hospital medicine revealed exquisite joint tenderness out of proportion with the history. Orthopedics was consulted who performed arthrocentesis which exhibited frank pus from all three joints. He was taken to the OR for I&D of joints with spacer placement of his prosthetic knee joint. Intraoperative cultures and blood cultures ultimately grew MSSA.

Discussion: In the above case, the patient's AMS, weakness, and joint pain were due to MSSA bacteremia, but misattributed to a UTI based on UA despite no urinary symptoms. AMS is not uncommon in elderly patients and UAs are often obtained as part of routine work up. Often, there is no further investigation into the cause of AMS if there is evidence of historical markers of a UTI (pyuria, leukocyte esterase, nitrites).

Thorough evaluation of AMS should include a quality physical exam, evaluating for lab abnormalities, organ dysfunction, recent

trauma, and new medications. In the absence of urinary symptoms, only when an alternative etiology cannot be identified should a UA be obtained due to the high prevalence of asymptomatic bacteriuria in older adults. A UA suggestive of a UTI in the absence of urinary symptoms is not indicative of an infection in need of treatment, but is rather a distracting piece of clinical information.

B9

A Rare Presentation of Uncontrolled Hypothyroidism in an Older Adult with Acute Psychosis

C. GREY. Geriatric Medicine, Penn State Health – Milton S. Hershey Medical Center, Hershey, PA.

New-onset neuropsychiatric symptoms in older adults commonly reflect underlying medical illness, and rare endocrine disorders can manifest with prominent psychiatric features (1). Diagnosis can be challenging, particularly when cognitive or functional vulnerabilities mask underlying reversible medical conditions.

A 79-year-old woman with hypothyroidism, living alone, called emergency services for a presumed spider bite, but paramedics found her confused and erratic, with no rash or bite marks. In the emergency room, she exhibited severe agitation, pressured speech, paranoid delusions, and disorganized thinking. She had no psychiatric history, and family reported these symptoms were new. On arrival, she had hypotension, otherwise normal vital signs and physical findings.

Laboratory testing revealed profound hypothyroidism (TSH 74.8 µIU/mL, low free T3 and T4), mild transaminitis, and mild hyponatremia; urine toxicology was negative. Geriatric medicine was consulted for acute agitation and cognitive assessment. A diagnosis of myxedema psychosis due to severe hypothyroidism was made. Intravenous levothyroxine, lithium, and hydrocortisone were initiated and she required short-term antipsychotics for agitation.

Her mental status improved significantly over the following week, becoming calm and cooperative with only mild disorientation. Further history from the family revealed a two-year progression of cognitive impairment, likely contributing to interruptions in prescribed levothyroxine.

This case highlights how unrecognized neurocognitive disorder can lead to medication mismanagement with severe metabolic and neuropsychiatric consequences. It reinforces the need to maintain a high index of suspicion for reversible medical causes of new-onset psychosis in older adults, especially when rare presentations resemble dementia-related or primary psychiatric conditions.

References:

(1) Krüger J, Kraschewski A, Jockers-Scherübl MC. Myxedema Madness - Systematic literature review of published case reports. *Gen Hosp Psychiatry*. 2021;72:102-116. doi:10.1016/j.genhosppsych.2021.08.005

B10

Fluctuating Capacity, Conflicting Directives and Surrogate Ambivalence in an Veteran with Advanced CVD and Dementia: Case Report

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Background Determining capacity in individuals with dementia and superimposed delirium is challenging, particularly when documentation is fragmented and surrogates have limited knowledge of patients' wishes. American Geriatrics Society (AGS) guidance treats capacity as decision and time specific, using a standard four-abilities framework. This case shows how applying that framework can be challenging in intermittently delirious veteran with advanced heart failure (HF) and ambiguous advance directives.

Case Presentation An 80 year old veteran with severe aortic stenosis, HF and mixed vascular/Alzheimer's dementia was discharged

from a VA hospital to a facility after recurrent falls and confusion. Cognitive testing showed moderate impairment with poor appreciation of his diagnoses and prognosis. He lacked capacity due to fluctuating attention and inability to appreciate the consequences of his HF. Medical power of attorney (mPOA) reported the patient's wishes for life prolonging treatment and artificial nutrition- wanting "things done unless it would not make a difference," but struggled to translate this into clear choices during recurrent decompensations.

Palliative team during hospitalization deemed him capable of making his own decisions in advance care planning. However, at the long term care facility, patient showed intermittent lucidity during goals-of-care discussions: he often refused to discuss death. It took multiple reassessments for staff to document a lucid interval, in which he stated that if he had only days or weeks to live, he would prefer not to be resuscitated. Navigating the patient's preferences were difficult, in the context of conflicting past directives favoring maximal life-prolonging care and with the mPOA's tendency to default to full code. Though it was difficult to derive, his ultimate decision to be DNR showed his true preference when he was able to clearly understand the prognosis.

Conclusion In patients with advanced cardiovascular disease, dementia, and intermittent delirium, honoring preferences is ethically fraught especially when records are incomplete and surrogates have limited insight. This case highlights the need for AGS guided, cross-system approaches that rely on repeated capacity assessments, reconstruction of values, and structured support for surrogates to reach an ethically defensible plan of care.

B11 Resident Presentation

A Case of Oral Baclofen Withdrawal

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Case Presentation

An 83-year-old female with a history of ischemic stroke, hypertension, and diabetes mellitus presented for pre-syncope. Physical examination was unremarkable and without orthostasis. Workup revealed mild hyponatremia but was otherwise unremarkable. Important home medications included oral baclofen 10 mg BID, amantadine, gabapentin, hydroxyzine, lisinopril, and melatonin. Given concern for polypharmacy, her baclofen and gabapentin were held. Two days afterwards, she developed labile hypertension, worsening mental status, right-sided spasticity, cogwheel rigidity, and echolalia. Head imaging was unremarkable. On hospital day 5, her Bush-Francis Catatonia Rating Scale score was 14. This improved to 7 thirty minutes after a lorazepam challenge with a temporary resolution of her catatonic symptoms and right-sided spasticity. Two hours later, she regressed to a score of 15. After resuming her baclofen, she made stepwise improvements in both mental status and cognitive function. By hospital day 10, she returned to her cognitive baseline.

Discussion

Oral baclofen has been used since the early 1960s for various neurological disorders, including spasticity (1). Baclofen primarily works via activation of GABA_B receptors, leading to hyperpolarization of the pre-synaptic neuron membrane via potassium influx. Chronic baclofen use leads to downregulation of GABA_B receptor expression. Abrupt cessation of GABA_B receptor agonism leads to neural hyperactivity, leading to baclofen withdrawal symptoms such as muscle rigidity, altered mental status, and autonomic instability. Reports of abrupt cessation of intrathecal baclofen withdrawal are well described; however, oral baclofen withdrawal causing catatonia is a rare phenomenon (2). Given the wide variety of ways catatonia can present, the exact pathophysiology is difficult to discern. Regardless of administration route, baclofen should be cautiously tapered due to the potentially severe sequelae associated with baclofen withdrawal.

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B12

Hidden in Plain Sight: Post-Immunotherapy Adrenal Failure Presenting With Nonspecific Symptoms in an Older Adult

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Background:

Immune checkpoint inhibitors, including dostarlimab, have transformed oncologic treatment but carry risk of immune-mediated endocrinopathies. Adrenal insufficiency, while rare (~1.2% incidence in dostarlimab recipients), can present with nonspecific symptoms that overlap with age related and cancer related conditions, posing a diagnostic challenge in older adults.

Case Description:

A 75-year-old woman with FIGO Stage IIIC endometrial adenocarcinoma completed surgical management followed by 6 cycles of carboplatin/paclitaxel/dostarlimab and 8 additional cycles of dostarlimab monotherapy. Two months following therapy cessation, she presented with headache, fatigue, nausea, dizziness, and bilateral lower extremity edema. Initial renal, cardiac, vascular, and general laboratory evaluation revealed no acute pathology. She was admitted following borderline hypotension unresponsive to fluids. Endocrine testing revealed a morning cortisol of 0.5 µg/dL with minimal stimulation response (4.0 µg/dL at one hour; 4.7 µg/dL at two hours), consistent with adrenal insufficiency. She denied corticosteroid exposure. Hydrocortisone therapy was initiated, producing rapid symptomatic improvement.

Discussion:

This case highlights diagnostic complexity in older adults receiving immunotherapy. Symptoms of adrenal insufficiency (fatigue, dizziness, nausea, hypotension) may be misattributed to frailty, chemotherapy effects, or multimorbidity. Clinicians caring for geriatric oncology patients should maintain suspicion for immune-mediated endocrine toxicity, even months after treatment completion.

Conclusion:

Adrenal insufficiency from immune checkpoint inhibitor therapy, although uncommon, represents a clinically significant and potentially life-threatening condition in geriatric patients. Early recognition and prompt hormone replacement can rapidly reverse symptoms. Routine anticipatory monitoring and education regarding symptom triggers should be incorporated into the care for older adults exposed to PD-1/PD-L1 agents.

B13 Resident Presentation

Recognizing Dementia in the Hospital: Inpatient Detection of Agrammatic Primary Progressive Aphasia

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Introduction: Primary progressive aphasia (PPA) is a neurodegenerative syndrome characterized by language decline, often associated with frontotemporal lobar degeneration (FTLD) pathology. Differentiating PPA from sequelae of traumatic brain injury (TBI), recurrent head trauma, or mood disorders can be difficult when symptoms evolve slowly. Inpatient geriatric consultation can provide diagnostic clarity even during acute illness, challenging the reflex to defer dementia evaluation to the outpatient setting. **Case:** A man in his seventies presented with years of progressive language disturbance

and behavioral change. His spouse first noted hesitant, effortful speech and word substitutions in 2014. In retrospect, irritability and emotional lability preceded language decline. He had a remote TBI decades prior and recurrent falls with mild head trauma. Neuropsychological testing in 2015 revealed impaired phonemic fluency and slowed processing with preserved comprehension and visuospatial skills, interpreted as non-amnesic cognitive disorder. From 2017 to 2022, his speech became increasingly halting and vague, accompanied by worsening agitation. Multiple neurologic evaluations considered trauma-related cognitive disorder or parkinsonian syndromes, but symptoms did not respond to levodopa therapy. In 2025, he was hospitalized for encephalopathy of unclear etiology that self-resolved. Mood lability prompted geriatrics consultation. Comprehensive assessment identified expressive and receptive language deficits, impaired comprehension, and prominent irritability and depression. Speech-language pathology documented expressive and receptive aphasia with spared reading and writing at the phrase and sentence level. These findings seemed consistent with agrammatic PPA, later confirmed by an outpatient memory specialist who placed the patient within the PPA–FTLD spectrum. **Discussion:** This case illustrates that dementia can and should be recognized in the inpatient setting when reliable collateral supports chronic progression. The coexistence of language impairment, emotional dysregulation, and cognitive decline reflects the shared tau and TDP-43 proteinopathies linking PPA and frontotemporal dementia. Inpatient geriatric consultation was pivotal in synthesizing years of disparate findings, providing the family with long-sought diagnostic clarity for appropriate care planning.

B14

Outpatient vs. Inpatient Initiation: Impact on Hyponatremia Severity and Adverse Events from Antidepressant-Diuretic Therapy

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Background

The concurrent use of antidepressants and diuretics is a well-established risk factor for hyponatremia in older adults. However, the differential impact of chronic, outpatient exposure versus acute, inpatient initiation on clinical outcomes remains poorly characterized. Attribution of adverse outcomes is challenging due to the nonspecific nature of symptoms and confounding by multimorbidity. This study aimed to describe the distribution of hyponatremia severity and evaluate the frequency of adverse clinical outcomes among older adults admitted with low serum sodium, stratified by the timing of their concurrent therapy initiation (Outpatient vs. Inpatient).

Methods

A descriptive case series utilized retrospective chart review at a single non-profit hospital for encounters in the 2024 calendar year. The population included patients ≥ 60 years of age receiving an antidepressant concurrent with a diuretic who developed confirmed hyponatremia (corrected Na < 135 mEq/L). Severity was classified as mild (130–134), moderate (126–129), or severe (< 125 mEq/L). The final cohort was stratified into Outpatient Initiation group and Inpatient Initiation group. Outcomes included length of stay (LOS), 30-day readmission, and adverse events (falls/confusion/weakness). Descriptive statistics used Mean $\pm$ SD or Median [IQR] as appropriate.

Results

The final cohort (n=63) averaged 76 ± 8.81 years old and was majority female and Hispanic. The median duration of established outpatient concurrent therapy (n=46) was chronic at 474 days [146–979]. The Inpatient Initiation Group (n=17) had a higher rate of hyponatremia on admission (88% vs. 65%) and a greater rate of severe hyponatremia (12% vs. 4%) compared to the Outpatient Initiation Group.

The Inpatient Initiation Group demonstrated a substantially longer median LOS of 13.5 days [3.5–17] compared to 4.5 days [2–8] for the Outpatient Group. Conversely, the Outpatient Initiation

Group showed a greater rate of adverse events (falls/confusion/weakness) (39% vs. 6%) and was the only group with observed mortality (n=4, 9%). Readmission rates were comparable (Outpatient: 26% vs. Inpatient: 24%).

Conclusions

These findings suggest that while chronic exposure is linked to adverse events, acute illness necessitating admission and medication initiation presents the highest burden on hospital resources, reinforcing the need for proactive de-prescribing and monitoring in the outpatient setting.

B15

A Safer Option, Still Out of Reach: System Barriers to Treating Opioid Dependence with Buprenorphine in Older Adults

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Background: Adults with decades of long-term opioid therapy are entering older age with physiologic dependence and high vulnerability to opioid-related harms. Buprenorphine, a partial μ -opioid receptor agonist, has a ceiling effect on respiratory depression, minimal QT interval impact, and fewer drug–drug interactions than full agonists or methadone. Despite these advantages, buprenorphine remains underutilized in older adults, with low initiation rates.

Methods: We conducted a retrospective review of three inpatient geriatric consults (ages 71, 78, 72; all white women) at an academic hospital in which buprenorphine initiation (or rotation) was recommended for chronic opioid therapy with physiologic dependence. We extracted presenting syndromes, opioid exposure patterns, induction processes, and discharge prescribing responsibility. We qualitatively coded documentation for clinician discomfort, workflow barriers, and medication stigma.

Results: All three patients presented with opioid-related safety events linked to chronic short-acting opioids combined with sedatives or anticholinergics: benzodiazepine overdose, recurrent falls, and encephalopathy. Buprenorphine was initiated in all three, with improved alertness, stability, and participation in therapy. None had an outpatient clinician willing to assume prescribing at discharge. Hospitalists, geriatric clinicians, and home-visit providers cited limited familiarity with buprenorphine, misperceptions about regulatory requirements, and discomfort managing MOUD in older adults. In one case, the patient’s family expressed concern over medication stigma. In all cases, fragmented workflows and limited addiction capacity resulted in short bridge prescriptions without reliable post-discharge continuity.

Conclusions: These cases expose a systems-level gap: older adults with chronic opioid exposure may be ideal candidates for buprenorphine rotation, yet inpatient and outpatient structures are not designed to deliver it reliably. Barriers were primarily cultural (medication stigma), educational (clinician inexperience), and operational (no defined post-discharge pathway). Standardized inpatient protocols, cross-training with addiction medicine, and clear outpatient ownership are needed to integrate buprenorphine into geriatric care.

B16

A case for firearm screening and counseling for patients with dementia

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Background: The population of individuals living with dementia is growing, many of whom have access to firearms. This poses a significant safety risk, as cognitive decline and dementia are independent risk factors for suicide and aggression.¹ Though clinicians routinely screen and provide anticipatory guidance for other health

risks, firearm safety assessment and counseling is often neglected.¹ Consequently, caregivers lack guidance for managing firearms as cognitive impairment progresses.² This case illustrates morbidity due to lack of firearm safety planning in a patient with dementia.

Case: RC is a 67-year-old male with mild dementia who was transferred from an outside hospital for facial reconstruction after a self-inflicted gunshot wound. The geriatric medicine team was consulted and learned from the patient's family that he had progressive cognitive decline over the preceding 4 years. He followed with neurology for this since 2022 and had regular visits with primary care where dementia was discussed. Access to firearms was not documented in any notes preceding this injury, and the patient's family noted no questions or counseling surrounding firearms in prior encounters with his clinicians. At the time of his injury, RC was living in the basement of his home, adapted for him to live mostly independently. He had numerous guns in the basement, though he had not hunted for many years. RC was found shortly after the gun fired, and it was unclear whether the self-inflicted wound was intentional.

Discussion: This case highlights a major gap in risk assessment and counseling for a patient with dementia. For an individual with many touch points with health care, firearm access and safety were not addressed. This fits within broader findings, shown in a survey of caregivers of persons with dementia, where only 5% reported that any health care professional had spoken to them about firearm safety.² This case demonstrates the need for harm reduction assessment and counseling for firearm safety in this population.

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B17

Unmasking Cushing's Syndrome: Challenges of Diagnosis in Older Adults

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Background

Cushing's Syndrome (CS) is a rare condition marked by cortisol excess. The presentation in older adults can be atypical and include non-specific symptoms such as generalized weakness and fatigue making timely diagnosis more difficult. This case illustrates the challenges of diagnosing CS in the geriatric population and its potentially fatal complications.

Case

A 77-year-old woman with a history of T2DM managed with an insulin pump, HTN, and left adrenal adenoma presented repeatedly over two months with progressive weakness, fatigue, daytime somnolence, and recurrent electrolyte abnormalities. During her third presentation for similar symptoms, her labs showed hyponatremia, hypomagnesemia, hypokalemia, and mildly suppressed TSH with a normal free T4. Physical exam revealed new facial swelling, hirsutism, and increased lower extremity edema. Endocrinology was consulted for insulin management and recommended further evaluation of her symptoms, including a 24-hour urine free cortisol level and dexamethasone suppression test which confirmed hypercortisolism.

While awaiting additional studies to determine the source of cortisol excess, she developed acute encephalopathy and was intubated for airway protection. An elevated ACTH level indicated an ACTH-dependent process. Brain MRI revealed a 3-mm pituitary microadenoma and inferior petrosal sinus sampling (IPSS) confirmed a central ACTH source consistent with Cushing's disease. Her clinical status continued to worsen and she developed septic shock from

multiple opportunistic infections, including *Pneumocystis jirovecii* pneumonia, COVID-19, rhino/enterovirus, adenovirus, *Moraxella*, and VZV viremia. Despite medical blockade of cortisol excess with ketoconazole and etomidate, her multi-organ failure was refractory. Her family elected to transition her to comfort care.

Discussion

CS in older adults may present insidiously with symptoms easily attributed to comorbidity, aging, or functional decline. Early recognition is critical, as severe glucocorticoid excess can lead to profound immunosuppression and life-threatening multi-organ dysfunction before definitive treatment is possible. IPSS remains the gold standard for localizing ACTH-dependent CS.

B18

From Pediatrics to Geriatrics: A Misdiagnosed Panniculodermatitis Exacerbated by Poly-topical Overload

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Background: Jacquet erosive dermatitis, a severe erosive irritant dermatitis with deep ulcerations, is seen infrequently in pediatrics and can also rarely affect geriatric patients.

Case: An 88-year-old woman with urinary incontinence presented with excoriated papules on the back and buttocks and was treated empirically for scabies. Over subsequent visits she developed axillary ulceration, recurrent intertrigo, and ulcerative plaques concerning for HSV and bacterial superinfection, prompting multiple empiric therapies, including ivermectin, doxycycline, valacyclovir, antifungal therapy despite negative herpes simplex virus (HSV) testing. Her condition worsened with escalating pain and ulcerations, leading to hospital admission for suspected disseminated HSV. Biopsies revealed nonspecific ulceration and reactive epidermal hyperplasia. Further review revealed prior use of vitamin E oil, triple-antibiotic cream with pramoxine, and lidocaine, indicating severe irritant contact dermatitis that was exacerbated by barrier occlusion from these topical agents. She improved with wound care, zinc oxide, and lidocaine jelly and was discharged home.

Discussion: The adult literature on Jacquet erosive dermatitis is limited to a small number of case reports involving patients with urinary or fecal incontinence and lesions of the gluteal, inter-thigh, or perineal regions¹. Because histology is nonspecific, and the condition can mimic other ulcerative, infectious, or neoplastic disorders, it is a clinical diagnosis that is likely underrecognized and underreported². This case highlights the need to reconsider this uncommon but likely overlooked diagnosis in the geriatric population.

Conclusion: Jacquet erosive dermatitis, often considered a pediatric diagnosis, is likely underrecognized in older adults, where the skin barrier may be compromised due to age-related changes and chronic irritant exposure.

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B19

Geriatric Case Report: Delay in Diagnosing a Rare Disease

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Background: Older adults typically have a more complex medical history and may manifest disease processes differently than younger patients, often leading to delayed or incorrect diagnoses. Statistics comparing diagnostic workup times for similar symptoms

between geriatric and younger patients are limited, but the available evidence consistently points to longer delays for older adults across multiple acute and chronic conditions¹¹⁻⁵¹. In this case review, we discuss a complex geriatric patient who develops vague symptoms and is eventually diagnosed with a rare lymphatic disorder one year after symptom onset.

Case: An 84 year old female with a past medical history of breast cancer presents to a family medicine clinic for fatigue and unintentional weight loss since her routine hip replacement one month prior. She was found to have developed a postoperative anemia and also reported that she had COVID-19 one week prior to her operation. Given her frailty, her symptoms were thought to be most likely related to her recent illness, surgery, and new anemia. However, when symptoms did not improve, further workup was initiated. Over the course of a year, several diagnoses were considered and treated including severe mesenteric artery stenosis, an ovarian lesion, and colitis. After symptoms failed to improve with interventions, a video endoscopy finally led to the correct diagnosis eleven months after symptom onset began. The patient is now being treated for acquired intestinal lymphangiectasia by Cleveland Clinic and is doing well.

Learning Points: Vague symptoms are sometimes viewed as “normal” aging, which may delay a patient to seek care and prolong the medical workup. If symptoms persist despite adequately treating common causes, further workup for rarer etiologies is appropriate. A thorough workup is indicated for all patients, regardless of age or frailty, if it aligns with their goals of care.

* Please refer to the citation section included on the associated poster.

B20

Severe hyponatremia due to SGLT2 inhibitor (SGLT2i) in a frail older patient

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Introduction: Older adults are particularly susceptible to hyponatremia due to age-related reductions in urine-concentrating ability and a blunted thirst mechanism. Severe hyponatremia manifests with significant neurological symptoms and can be life-threatening. We present a case highlighting how SGLT2 inhibitor-associated osmotic diuresis may precipitate severe hyponatremia in frail older adults living in long-term care.

Patient Information: Patient is an 83-year-old long-term care resident with type 2 diabetes, chronic kidney disease, and a history of cervical spine surgeries resulting in quadriplegia, dysphagia, and vocal cord paralysis, with percutaneous endoscopic gastrostomy (PEG) tube and tracheostomy. He was seen for asymptomatic, gradually worsening hyperglycemia for a week. On the following day, he developed hypoactive delirium and tachypnea without hemodynamic instability. Glucose worsened despite additional doses of short-acting insulin and increased free water flushes via PEG. Laboratory results revealed sodium >165 and glucose of 597. He was transferred to the emergency department and admitted to the intensive care unit for management of Hyperglycemic Hyperosmolar State (HHS). After a prolonged hospital course, requiring aggressive intravenous fluid resuscitation and ruling out additional causes for hyponatremia, the patient was readmitted to long-term care. On medication review, we identified that he was on empagliflozin, which was the likely driver of osmotic diuresis, leading to severe dehydration and HHS.

Discussion: Although prior studies demonstrate that SGLT2i are generally safe and well-tolerated in older adults, individual factors should be considered when deciding on their use. In this case, patient's inability to replete fluid loss due to PEG dependence led to silent dehydration. Additionally, evidence supports that older adults do not consistently show clinical signs of dehydration. Also, he failed to demonstrate compensatory hemodynamic changes of hypovolemia,

such as tachycardia, likely due to severe frailty and a narrowed physiological reserve. Clinicians should exercise caution when prescribing SGLT2i for individuals who cannot compensate for rapid changes in fluid status, such as those with impaired mobility, limited access to extra fluids, or cognitive disorders.

B21

A Case Report of Benign Prostate Hyperplasia Complicated by Spontaneous Intra-Peritoneal Urinary Bladder Rupture

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A 73-year-old man with severe benign prostatic hyperplasia (BPH) presented with acute diffuse abdominal pain and anuria following two weeks of progressively reduced urine output. Initial evaluation revealed metabolic acidosis and acute kidney injury. Computed tomography (CT) of the abdomen and pelvis demonstrated intraperitoneal free fluid, bladder distension, and bilateral hydronephrosis, suggestive of intraperitoneal bladder rupture. Exploratory laparotomy confirmed a 1.5 cm laceration on the superior bladder wall, with approximately 2 L of urine within the peritoneal cavity. The defect was surgically repaired and the patient managed postoperatively with bladder drainage, intravenous antibiotics for Staphylococcus epidermidis bacteremia, and supportive care.

Early postoperative course was notable for mild delirium that resolved with supportive care. Repeat CT imaging demonstrated multiloculated perivesical fluid collections (6 × 4 × 5.6 cm) and a right pararectal abscess (4 × 3.5 × 2.4 cm), which were managed conservatively with continued intravenous antibiotics. Follow-up CT showed marked reduction of the abscesses and no residual free fluid. Renal function normalized and inflammatory markers improved. The patient completed a four-week course of intravenous cefazolin and was discharged in stable condition with the Foley catheter in situ.

This case underscores the diagnostic challenge and importance of early recognition of spontaneous bladder rupture secondary to BPH, a rare but potentially life-threatening urologic emergency.

Keywords: Spontaneous bladder rupture, Benign prostatic hyperplasia, Uroperitoneum, Urinary retention.



B22 Student Presentation, Encore Presentation

FluMel100 with post-transplant cyclophosphamide: A safe and effective regimen for patients aged ≥75 years with MDS and AML

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Introduction

Allogeneic hematopoietic cell transplantation (allo-HCT) is the only curative therapy for many older adults with AML and MDS, yet patients ≥75 years remain underrepresented due to concerns about frailty, toxicity, and mortality. Most prior studies in this population used heterogeneous non-myeloablative or RIC regimens. This study evaluates the feasibility and outcomes of a uniform

fludarabine-melphalan 100 mg/m² (FluMel100) conditioning regimen with post-transplant cyclophosphamide (PTCy) in adults ≥75 years.

Methods

We retrospectively reviewed adults ≥75 receiving FluMel100 and PTCy between September 2023-March 2025. Eight patients underwent allo-HCT (PTCy 80 mg/kg n=7; 50 mg/kg n=1) using peripheral blood grafts from HLA-matched unrelated donors with tacrolimus/mycophenolate prophylaxis. Pre-transplant geriatric assessments included MoCA, Mini-COG, TUG, STS, G8, and Edmonton Frailty Scale. Outcomes included engraftment, GVHD, relapse, survival, and immunosuppression discontinuation (IST).

Results

Eight patients were included (7 AML, 1 MDS; median age 76). Karnofsky scores were 80-90% and HCT-CI 0-7. All engrafted, with 100% CD33⁺ chimerism at days +30/+100 and CD3⁺ chimerism 88-100% at day +30 and 95-100% at day +100. Median time to ANC >500/μL was 14.5 days, ANC >1000/μL 15 days, platelets >20×10⁹/L 19.5 days, and >50×10⁹/L 22.5 days. Median inpatient stay was 23 days (15-30). No ICU care was required, and all were discharged home. At a median follow-up of 422 days (116-756), 1-year OS was 100% and RFS 87.5%. Acute GVHD occurred in 4/8 (50%), all skin-limited (grade 1 n=3; grade 3 n=1). Six patients (75%) discontinued IST, median 297 days off therapy (154-728). One patient remains on IST; one relapsed but achieved durable remission after DLI.

Conclusion

FluMel100 allo-HCT with PTCy is well tolerated in carefully selected adults ≥75 years, with reliable engraftment, encouraging survival, and manageable GVHD. Most patients discontinued IST within one year, suggesting durable tolerance and functional recovery. These findings support consideration of allo-HCT for fit adults ≥75. Ongoing work will assess chronic GVHD and quality-of-life outcomes.

B23

From Bilateral to Unilateral: A Safer ECT Approach for Late-Life Catatonia

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Background

Catatonia, a syndrome marked by motor, behavioral, & autonomic abnormalities, is underrecognized in older adults, often delaying treatment and increasing morbidity. We present a case of an older adult with refractory catatonia that required Right unilateral (RUL) electroconvulsive therapy (ECT).

Case Presentation

A 75-year-old woman with major depressive disorder, severe anxiety, & hypertension presented with worsening paranoia, tangential thought process, poor sleep, & 10-pound weight loss. She believed she was being tracked by an international conspiracy group trying to steal her social security. At baseline, she was independent with her basic and instrumental ADLs. Physical exam on presentation revealed a disheveled appearance, constricted affect, tangential thought process & paranoid delusions. Laboratory studies (CBC, CMP, TSH, B12, urine toxicology) were within normal limits. CT head, chest, abdomen, pelvis & MRI brain showed no acute abnormalities. Olanzapine trial for major depression disorder with psychosis was ineffective. On hospital day 6, Bush-Francis Catatonia Rating Scale score was 9/23 (screening) and 12/23 (severity) indicating moderate catatonia. Lorazepam trial showed partial improvement, but social withdrawal & poor oral intake persisted. ECT was initiated with bilateral electrode placement due to institutional practice. Despite improvement, ECT was stopped after four sessions due to confusion. RUL ECT was then initiated & after two sessions, the patient demonstrated dramatic improvement in social interaction, oral intake, & cognitive clarity, allowing discharge with planned outpatient ECT.

Discussion

Catatonia in older adults is often underrecognized due to symptom overlap with dementia & delirium. Though benzodiazepines are first-line therapy, ECT is indicated for refractory cases or when faster response is needed as in malignant catatonia. While traditional bilateral ECT is considered more potent, it can cause cognitive side effects as it did in this case, emphasizing the importance of electrode placement decision. RUL ECT is highly effective with fewer cognitive side effects, making it preferable in older adults.

Conclusion

Early recognition of catatonia & appropriate electrode placement is crucial. RUL ECT provides effective treatment while preserving cognitive function in older adults.

B24 Resident Presentation

Same Day Discharge After Primary Total Joint Arthroplasty in Octogenarians

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Background:

Demand for total joint arthroplasty (TJA) continues to increase in an aging population, making it essential to evaluate outcomes in octogenarians (80 and older). Although advanced age is associated with medical complexity, frailty, polypharmacy, and higher perioperative risk, growing evidence supports favorable outcomes when patient selection and perioperative care are optimized. However, data on same day discharge following arthroplasties remain limited prompting this assessment of outcomes in octogenarians treated at our Total Joints Center

Methods:

A retrospective case series was conducted of octogenarians undergoing primary total hip (THR), total knee (TKR), or unicompartmental knee arthroplasty (UKR) at a single orthopaedic institution between 2020 and 2023. Demographics, perioperative metrics, and 90-day outcomes were collected from the electronic health records and institutional surgical database. A review of the literature was performed to contextualize these findings within current optimization strategies and clinical benchmarks for older arthroplasty patients.

Results:

Fifteen patients met the inclusion criteria, with a mean age of 81.6 years (range, 80-86), and 5 patients (33%) were female. Mean body mass index was 25.7 kg/m² (SD 2.3; range 21.9-29.1). Most patients were categorized as American Society of Anesthesiologists (ASA) II (n=12, 80%), with 2 ASA III (13%) and 1 ASA I (7%). The median Charlson Comorbidity Index was 4 (range 4-6). The most frequent comorbidities were hypertension (n=10), diabetes mellitus (n=3), and coronary/cardiovascular disease (n=1). There were 8 TKRs, 6 THRs and 1 UKR. Mean estimated blood loss was 100 ± 58 mL (range, 50-200), and mean operative time was 72 ± 19 minutes (range, 41-112). All patients were discharged on the day of surgery, with a mean discharge time from the facility of approximately 4 hours. There were no intraoperative complications, no readmissions within 30 or 90 days, and no perioperative adverse events were observed. Discharge disposition was home for all patients.

Conclusion:

Same-day primary TJA can be safely and effectively performed in carefully selected octogenarians through comprehensive preoperative evaluation and multidisciplinary care. These findings support the growing evidence that chronological age alone should not preclude surgical intervention and same day discharge in arthroplasty candidates.

B25 Resident Presentation

Can Denonvilliers' Fascia Fail With Age? A Case of Prostate Cancer Invading the Rectum

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Background

Prostate cancer is the most common cancer in men, with an estimated 313,780 new U.S. cases and 35,770 deaths in 2025. Early disease is usually asymptomatic, and most symptomatic presentations involve urinary obstruction or bone pain from metastases. Although the prostate lies adjacent to the rectum, direct rectal invasion is rare due to the protective Denonvilliers' fascia. As a result, rectal bleeding or a rectal mass as an initial presentation is exceptionally uncommon, making cases like this clinically significant.

Methods

We present a case of rectal bleeding due to prostate cancer to explore the underlying factors and the literature review of this infrequent presentation in older adults.

Results

A 67-year-old man with hypertension and benign prostatic hyperplasia presented with two months of worsening rectal pain and bleeding, 35 lb weight loss, fatigue, and weakness. Vitals were stable; labs showed mild normocytic anemia. The exam revealed hypogastric tenderness, blood on digital rectal exam, and an enlarged smooth prostate. Prostate-specific antigen was 92 ng/mL. Imaging showed an 11cm necrotic mass between the bladder and rectum. Colonoscopy revealed a large fungating, ulcerated rectal mass from 3–10 cm from the anal verge; biopsy showed mucosal, submucosal, and muscularis invasion by prostate adenocarcinoma. Subsequent prostate biopsy confirmed acinar adenocarcinoma, Grade 5, Gleason 5+5=10. He was started on chemotherapy and androgen deprivation therapy and remains under urology follow-up.

Discussion/Conclusion

Contiguous spread of prostate cancer to the rectum is rare because of the protective Denonvilliers' fascia. This tissue acts as a barrier, but in elderly patients, it can become stiffer and less elastic, making it less compliant and more prone to invasion. Therefore, in older male patients with unexplained rectal bleeding, prostate cancer should be considered, even if urological complaints are absent. This case underscores the diagnostic challenges associated with atypical presentations of prostate cancer; gastrointestinal bleeding and rectal pain can overlap with a broad range of differential diagnoses. A comprehensive clinical assessment and approach are essential for an accurate diagnosis, optimal patient management, and timely treatment.

B26 Student Presentation

Functional Movement Disorder (FMD) in Geriatric Clinic

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Background

FMD is a motor variant of functional neurological symptom disorder in DSM-5. FMD a rule-in diagnosis based on demonstration of abnormal movements or weakness inconsistency and incompatibility with other neurologic diseases. FMD is a common, potentially reversible disability. There are gaps in evidence on FMD diagnosis and management, which limits current clinical practice.

Case

In her first geriatric visit, Ms G, 67 yo female, on a wheelchair, with PMH of depression/anxiety, requested a power mobility device. 5 years ago, she had progressively worsened left arm and bilateral leg weakness, and frequent falls. Prior to that, she was a caretaker. She was diagnosed with Parkinson's Disease but did not follow up for years. Recently, a neurologist diagnosed her with FMD. On exam, her

severe leg weakness improved when she walked 5 steps unassisted. She showed a positive Hoover's sign: First, her left hip was weak while sitting. Next, the examiner kept her hand under the weak left knee when the patient flexed her right leg against resistance. Her left hip strength significantly increased. These are the signs of inconsistency and incongruence. All labs and MRI images were negative. The neurologist had ruled out Parkinson's disease and is currently ruling out Parkinsonian plus syndrome.

Discussion

Treatment of FMD starts with a crucial step - delivery of diagnosis: (1) FMD is an established diagnosis; (2) diagnosis is often made definitively with neurological exam, not a diagnosis of exclusion; and (3) FMD can be reversible with treatment. Patient acceptance of the diagnosis improves treatment compliance.

Studies support a tailored multidisciplinary approach that also addresses cognition and behavior, i.e., physical, occupation, speech therapy, with psychotherapeutic modalities. Where possible avoid compensatory aid when undergoing active rehab. For Ms G, a power mobility device is not appropriate because it can worsen function and mobility while increase her anxiety.

FMD does not preclude other concurrent or future neurological diagnosis, eg, Parkinson's disease. Re-referral to neurologist as needed. Routine fall screening and prevention education, eye exam, and osteoporosis screening are appropriate.

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Serranova et al. *Neurologic Clinics*, 2023;41;583-603

Nicholson et al. *J Neurol Neurosurg Psychiatry.* 2020;91:1037-45

B27

Recurrent Steroid-Responsive Encephalopathy in a Patient With Long-Standing Sarcoidosis: A Case Suggestive of Neurosarcoidosis

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Background: Neurosarcoidosis is an uncommon manifestation of systemic sarcoidosis and often presents with nonspecific neurologic symptoms that complicate timely diagnosis, particularly in older adults with multimorbidity. We describe a 75-year-old African American woman with long-standing pulmonary sarcoidosis, chronic hepatitis B, and triple-negative invasive mammary ductal carcinoma treated with bilateral mastectomy and chemotherapy, who developed recurrent episodes of altered mental status (AMS) ultimately suspected to reflect neurosarcoidosis despite nondiagnostic imaging and CSF studies.

Methods: Clinical, laboratory, and radiographic data from multiple hospitalizations in 2025 were reviewed. Evaluations included stroke workups, neuroimaging, CSF studies, hematologic testing, and assessment of infectious, environmental, and treatment-related immune triggers. Diagnostic reasoning emphasized exclusion of vascular, infectious, malignant, and immune-mediated causes, along with response to immunosuppression.

Results: The patient experienced repeated episodes of encephalopathy, expressive aphasia, and confusion. Stroke evaluations and CSF analyses were unrevealing. MRI demonstrated chronic micro hemorrhagic infarcts without leptomeningeal or parenchymal enhancement. Each episode improved dramatically with high-dose corticosteroids. Relevant risk factors included her underlying malignancy, chronic viral infections, remote travel to Africa and Brazil, and prior pembrolizumab exposure. Her course was complicated by SIADH-related hyponatremia and severe pancytopenia (platelet nadir 4,000/ μ L), with bone marrow biopsy showing trilineage hematopoiesis. She is African American, a population in which sarcoidosis is more common. She continues prednisone and infliximab with ongoing evaluation for recurrent AMS.

Conclusions: This case highlights the diagnostic difficulty of neurosarcoidosis when classic imaging and CSF markers are absent.

The patient's reproducible steroid responsiveness strongly supports an underlying inflammatory sarcoid-related process. Immune checkpoint inhibitor therapy, chronic infections, and underlying malignancy may have contributed to immune activation. Early recognition of these contributors is essential for timely diagnosis and treatment in older adults with sarcoidosis presenting with unexplained neurologic decline.

B28 Resident Presentation

Tailoring Lymphoma Care to What Matters Most: A Complex Geriatric Case

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Patient Story:

An 88-year-old woman with rheumatoid arthritis, secondary Sjögren's syndrome, coronary artery disease, atrial fibrillation, and vascular dementia presented with a new neck mass. Biopsy revealed CD10-positive mature B-cell lymphoma with t(14;18) translocation and BCL2 amplification, consistent with diffuse large B-cell lymphoma (DLBCL). She reported decreased appetite, 15-lb weight loss, fair energy, and recent falls. Despite living alone, she remained functional, taught English as a second language, and managed her finances. Cognition had declined, and neuropsychological testing confirmed vascular dementia.

Her goals prioritized quality of life, maintaining her hair, and avoiding profound fatigue. She declined standard chemotherapy and began reduced-intensity "mini-R-CGOP" (rituximab, cyclophosphamide, gemcitabine, vincristine, prednisone) with omission of doxorubicin. After three cycles and one hospitalization for pneumonia, she chose to stop chemotherapy and continue rituximab alone, accepting possible recurrence. She completed six cycles, tolerated treatment well, and achieved stable disease with resolution of lymphadenopathy. One year later, she remained in remission with improved appetite, weight gain (50 kg to 55 kg), and good energy.

Main Teaching Points:

This case highlights *Matters Most* as central to care planning. Therapy was tailored to align with the patient's preferences even at the expense of conventional aggressiveness. Mind, *Medications*, *Multicomplexity*, and *Mobility* also influenced decision-making in the context of early dementia, polypharmacy, multimorbidity, and fall risk. Social support enabled independence and adherence. This case illustrates how treatment, even when attenuated, can improve energy, appetite, and nutritional status despite the potential for initial side effects.

Discussion:

This case illustrates how identifying the 5Ms guides complex decision-making in geriatric oncology. Through shared decision-making and an interprofessional approach, treatment was individualized to balance efficacy with quality of life. Respecting her values led to adherence, disease control, and preserved function. Aligning care with what matters most can achieve meaningful outcomes, even with less intensive therapy, underscoring the importance of patient-centered approaches in older adults with cancer.

B29

Comparison Study of Incretin Mimetics Dosing on Older Adults: Geriatric versus Adult Weight Management Clinic

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Background: Obesity is increasingly impacting older adults. Incretin mimetics show promise for improving obesity related comorbidities in older adults. However long-term safety data remain limited. Age-related physiology may increase susceptibility to gastrointestinal intolerance and dehydration. This study aims to compare adverse events (AEs) including emergency department (ED) visits

and hospitalization due to incretin dosing regimens between clinics following an adult versus age-adapted algorithm in a geriatric clinic.

Methods: Retrospective chart review conducted on patients aged ≥ 65 at the adult Weight Navigation Program (WNP), n=14, utilizing a standard obesity treatment algorithm and the Optimal Health Weight and Lifestyle (OHWL) clinic, n=15 which followed a geriatric-adapted obesity management protocol that individualized therapy based on patient goals, functional status, comorbidities and a "start low, go slow" philosophy following initiation of semaglutide or tirzepatide (January 1, 2023 to September 31, 2025).

Results: 20.7 % identified as Black/African American, 75.9% as White, and 3.4% chose not to identify race. 62.1% identified as female and 37.9% as male. One patient from the OHWL clinic on the geriatric adapted regimen had an ED visit and hospitalization due to falls resulting in fractures. Two WNP clinic patients on the standard regimen had ED visits: One for ligament tear of the right knee and the other ED visit and subsequent hospitalization, experienced constipation and was diagnosed with a small bowel obstruction. Six OHWL patients discontinued semaglutide and 4 WNP patients discontinued semaglutide. P value calculated using Mann-Whitney U test.

Conclusions: Geriatric-adapted pharmacotherapy for weight loss is feasible for older adults with mobility limitations and frailty risk, with comparable adverse effects and acute event rate to standard approaches. Use should be tailored through shared decision-making, prioritizing individual needs and clinical complexity to optimize safety and outcomes while long-term efficacy data are pending.

Variable	Geriatric clinic (OHWL) N=15	Weight Navigation Program (WNP) N=14	p-value
Mean Age (YO)	77.9±4.3	70.3±3.4	<0.001
% Assistive device use	86.7 (13/15)	42.9 (6/14)	0.05
Weight Loss(%) 1-3mos Semaglutide	-1.5 IQR 7.6	-2.66 IQR 12.6	0.31
Weight Loss(%) 1-3mos Tirzepatide	-0.98 IQR 6.8	-10.2 IQR 8.45	0.12
AEs	6 GI 1 Hair loss 1 HA, Drug induced hepatotoxicity, and Unintentional weight loss 6 no adverse effects	3 GI 1 R superior ligament tear 8 no adverse effects	0.48
GLP related ED Visit	1	1	1.0
GLP related Hospitalization	1 (Falls with fracture)	1 (Small bowel obstruction)	1.0

B30 Resident Presentation

Aging With HIV: A Case for Geriatric-Centered Care

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HIV primary care needs to be an expanding focus in geriatrics. People living with HIV (PLWH) are living longer than ever: the life-expectancy gap between PLWH and the general population has narrowed from more than 20 years to less than 10, and those on stable ART with CD4 counts >500 now live only a few years fewer [Trickey]. Currently, 38% of people with HIV in the US are 55+, and this group is growing. Geriatricians must know HIV-specific guidelines, including risks for cardiovascular disease (CVD) and osteoporosis. Earlier screening and tailored assessments can prevent missed opportunities for intervention.

An 84-year-old female presented to her HIV primary care physician for follow-up of well-controlled HIV, hypertension, hyperlipidemia, and osteoporosis. She was diagnosed with HIV in 1995 at age 55 after acquiring the virus from her husband. She initially received zidovudine, lamivudine, and indinavir. In 2017, she transitioned to Trumeq. Her first DEXA scan in 2016 at age 76 showed osteoporosis, and risedronate was initiated. At age 75, her ASCVD risk was 19.4%. In 2025, her regimen was switched from Trumeq to Dovato to avoid abacavir, given its association with increased cardiovascular events in patients with elevated risk. She has since remained clinically stable without CV events or fractures and remains active with her family.

This patient lived with HIV long before guidelines recommended osteoporosis screening. Increased rates of bone loss in PLWH, especially those exposed to early protease inhibitors, were recognized in the early 2000s [Dybul]. She received indinavir for several years but

was not screened for osteoporosis until age 76. Newer data also highlight bone loss associated with tenofovir disoproxil fumarate (TDF); switching to tenofovir alafenamide (TAF) reduces fracture risk by 32% [Kim]. Preventing fractures is essential, as hip fractures carry a 20–25% one-year mortality rate [Ferris].

CVD is now a leading cause of death among PLWH. The REPRIEVE Trial and its 2025 secondary analysis showed increased major cardiovascular events with current or past abacavir exposure [Fichtenbaum]. Our patient fit this risk profile and was appropriately switched to a non-abacavir regimen.

This case underscores the importance of integrating geriatric principles into HIV care. Geriatricians must look beyond viral suppression to include preventive screening, medication effects, and the broader goal of promoting healthy, meaningful longevity—an outcome once thought unlikely for this population.

B31 Student Presentation

Cannabis Use for Chronic Pain in a Frail Older Adult

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Background

Cannabis use has increased among older adults following deregulation, yet most clinical trials exclude this population due to multimorbidity, polypharmacy, and higher vulnerability to adverse drug events. Evidence supporting the safety and effectiveness of Cannabis in geriatric patients with chronic pain remains limited. The objective of this case report is to describe the evaluation of a frail older adult using multiple Cannabis formulations for chronic pain in the context of complex comorbidities and high fall risk.

Methods

This case was identified during a pharmacist visit at a geriatric outpatient clinic serving adults aged 65 years and older. A comprehensive clinical medication review was conducted, including chart review, assessment of Cannabis product composition, evaluation of drug interactions, functional status assessment, and safety screening. The patient is an 87-year-old male, White, with a recent fall and chronic nonhealing ulcer limiting mobility. Past medical history includes hyperlipidemia, benign prostatic hyperplasia, hypercalcemia, atrial fibrillation, spinal stenosis, and peripheral artery disease. He previously failed trials of gabapentin and oxycodone-acetaminophen. Current pain regimen includes prednisolone taper and cannabis 2 to 4 times daily using tinctures (30mg:1mg CBD: THC; 49.5mg: 16.5mg CBD, 16.5mg THC, 16.5mg CBN) and gummies (20mg CBD:1mg THC).

Results

Medication review identified clinically significant risks related to cannabis use, including potential CYP450 mediated drug interactions with apixaban and tamsulosin, increased dizziness, impaired balance, and exacerbation of fall risk in the setting of frailty and limited mobility. Cannabis products provided inconsistent relief, and neuropathic features of pain remained uncontrolled. Following pharmacist assessment, recommendations were made to avoid CBD and THC products, reassess neuropathic pain etiology, and consider safer evidence-based alternatives. Coordination with the primary care provider was initiated.

Conclusion

This case highlights the need for individualized pharmacist evaluation of Cannabis use in frail older adults. Careful assessment of drug interactions, adverse effects, and functional status is essential to prevent harm. Incorporating pharmacists into geriatric care can optimize pain management and improve patient safety as Cannabis use continues to rise in this population.

B32 Student Presentation

The Use of a Risk Calculator to Guide Surgical Decision Making and Goals in an Older Adult with Cirrhosis and Newly Diagnosed Colon Cancer

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Background: Decisions about cancer care in older adults can be complicated by multimorbidity, frailty, and impaired decision-making capacity. Here, we present a case highlighting challenges of surgical decision-making in a patient with cirrhosis, new colon cancer, and multiple geriatric syndromes.

Case: A 74-year-old woman with a history including chronic pancytopenia, decompensated cirrhosis (with portal hypertension, esophageal varices, splenomegaly), hypothyroidism, bipolar disorder, COPD, stroke, and hypertension presented with delirium and a fall, found to have *Streptococcus cristatus* bacteremia. Collateral history revealed progressive dementia and months of persistent diarrhea, poor oral intake, and weight loss. Colonoscopy was previously not completed due to concerns about not tolerating bowel prep and anesthesia. Inpatient colonoscopy revealed a nearly completely obstructing descending colon mass with biopsy confirming invasive adenocarcinoma. Given her frailty, dementia, and functional status (dependence for IADLs and prompts for self-care ADLs) at baseline, the surgical team and daughter (healthcare proxy) were concerned about her ability to manage an ostomy. The VOCAL-Penn risk calculator predicted 30, 90, and 180-day postoperative mortality rates of 11.8%, 22.7%, and 30% respectively, for open abdominal surgery. After interdisciplinary discussions among surgery, gastroenterology, medicine, palliative care, and the daughter, the decision was made to forego surgery and pursue colonic stenting. She was discharged to a skilled nursing facility for rehab with plans for ongoing goals-of-care conversations, including about hospice.

Conclusions: This case demonstrates how predictive tools such as VOCAL-Penn, which was validated in a veteran population with a median age of 64 and incorporates age and cirrhosis-related variables, can guide decision-making and prognostication for older adults with cirrhosis. Commonly used risk calculators, like the ACS NSQIP, may not capture organ-specific risks, such as with cirrhosis, and thus can underestimate overall surgical risk. Tools that incorporate organ-specific risks are especially important in older adults, whose vulnerabilities can be magnified by their multimorbidity and reduced physiologic reserve, and can help patients and families make informed decisions that align care with their values and preferences.

B33

Black Hairy Tongue: A case for close oral exams in hospitalized older adults

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Introduction

Black hairy tongue (BHT) is a benign condition of tongue discoloration most notable on the dorsal surface, sparing the tip and lateral regions. It is associated with poor oral hygiene, dry mouth, soft diet, and medications, including antibiotics, proton pump inhibitors (PPI), and psychotropics. The increased prevalence in older adults is attributed to age-related changes in oral health and more frequent use of medications associated with BHT. We present a case of a 75-year-old man who developed black hairy tongue while hospitalized with introduction of new drug classes.

Case

A 75-year-old male with a history of hypertension, type 2 diabetes, traumatic brain injury, dementia, alcohol use, nonsmoker, was hospitalized after a fall with head trauma, resulting in intracranial hemorrhages. He was managed in intensive care with neurologic checks, blood pressure control, and antiseizure prophylaxis with

levetiracetam. He received a daily PPI for stress ulcer prophylaxis in the setting of head trauma. His hospital course was complicated by hyperactive delirium, necessitating treatment with psychotropic medications. 7 days after admission, our patient was noted to have dark discoloration of the tongue that was difficult to scrape off with a toothbrush or careful oral care.

Discussion

Black hairy tongue (BHT) is characterized by discoloration and elongation of filiform papillae on the tongue. This is thought to be secondary to accumulation of squamous epithelial cells, increased keratin retention, and proliferation of chromogenic microorganisms. BHT is associated with smoking, oxidizing mouthwashes, dry mouth, Candida infection, poor oral hygiene, soft diet, and prolonged hospitalization in patients with a gastrostomy tube. Drug-induced BHT can occur secondary to drugs that change oral flora or cause xerostomia, including PPIs, psychotropics, and antidepressants. BHT can develop within days to weeks, especially when triggered by new medication exposures, or abrupt changes in oral hygiene, as was noted in our patient. Diagnosis of BHT is clinical and treatment involves improving oral hygiene and removal of offending agents. BHT is often asymptomatic but can cause dysgeusia, impacting appetite and food intake, thus affecting recovery and prolonging hospitalization. This case highlights the need for a daily oral exam and thorough oral care for hospitalized older adults who are initiated on high-risk medications.

B34 Resident Presentation

Late-Onset Myasthenia Gravis in a 93 Year Old Woman With Frailty and Vascular Dementia

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Background

Myasthenia gravis (MG) can present de novo in nonagenarians and may mimic stroke, frailty, or delirium in older adults. Diagnostic uncertainty and goals of care (GOC) complexity often delay treatment. We report the case of a 93 year old woman with vascular dementia and frailty who's bulbar symptoms and generalized weakness was initially thought to represent cerebrovascular or neurodegenerative decline, but was ultimately diagnosed as antibody-positive MG with dramatic reversibility following targeted therapy.

Methods

This single-patient observational case describes a retrospective review of inpatient and post acute care records from May-July 2025 at Maine General Medical Center, Glenridge Rehabilitation, and the Alzheimer's Care Center. Data included neurologic, geriatric, and primary care documentation, imaging, electrophysiology, and antibody testing. Clinical outcomes were measured via functional status (ambulation, swallowing, and ADL independence), pulmonary function (negative inspiratory force), and medication tolerance through 10 week follow-up.

Results

The patient presented with 5 weeks of progressive ptosis, dysarthria, and respiratory weakness. MRI and CSF were nondiagnostic; the ice-pack test was positive. IVIG and high dose methylprednisolone were initiated. NIF improved from -15 to -40 cm H₂O. After transient comfort measures only status due to respiratory decline, she recovered sufficient strength to ambulate with therapy. AChR-binding antibody was markedly elevated (93.8 nmol/L) and modulating antibody 81%. She was transitioned to prednisone, pyridostigmine, and later azathioprine. At 8 week follow-up she demonstrated full bulbar recovery, normal gait with walker, and no aspiration events. Subsequent leg cramps were managed conservatively; no MG relapse occurred.

Conclusions

Even in advanced age with frailty and dementia, MG remains a reversible neuromuscular cause of functional decline. Recognition of

MG in this population demands a high index of suspicion and nuanced GOC discussions to balance aggressive but time limited interventions with patient values. IVIG and steroid therapy can yield meaningful recovery and restored quality of life, emphasizing the need for multidisciplinary collaboration between geriatrics, neurology, and rehabilitation teams when managing acute neuromuscular syndromes in older adults.

B35

More frequent than recognized- The Musical Ear Syndrome

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Background: The Musical Ear Syndrome is an often under-recognized and under-reported entity by medical teams that consists of auditory hallucinations, which are specifically musical hallucinations. This case is an illustration of an overlooked case of the "Musical Ear Syndrome" to raise awareness among geriatric providers.

Methods: We reviewed patient's medical records over the last 15 years looking for documentation that mentioned evaluation of her hearing loss, hallucinations, mood and cognition.

Results: This is an 86-year-old female with hearing loss and legal blindness admitted with bronchiectasis and COPD exacerbation, who endorsed the presence of persistent musical hallucinations for the last 15 years. She described the symptoms as hearing various songs. They subside when she is engaged in activities like watching a movie or conversing. They are most bothersome at night and cause difficulty falling asleep. At the time of her first sharing her concerns with her primary care physician, a neurology referral was completed with MRI brain and EEG which were unremarkable. She has not had any cognitive decline and her current MOCA was in normal range. She used hearing aids that initially helped reduce the hallucinations but are now ineffective. Since she has had many doctor's visits for different unrelated medical conditions and although this was continuously a complaint, she felt her symptoms were not taken seriously, so stopped mentioning them to providers.

Conclusions: We present this case to highlight the impact of Musical Ear Syndrome on a patient's quality of life. Sensory deprivation is a common contributing factor for musical hallucinations in the elderly, regardless of whether cognitive loss is present, and some cases can have multiple contributing factors.

B36 Resident Presentation

Can't See the Forest Through the Trees: Diagnosis of MSA After Multiple Hospitalizations

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Background: Multisystem atrophy (MSA) often presents over many visits with symptoms that appear unrelated. Its overlap with movement and cardiac disorders contributes to frequent misdiagnosis. Short hospital stays and rapid discharges further delay recognition of complex neurodegenerative conditions like MSA, which require longitudinal assessment.

Case Presentation: An 82-year-old man with ischemic heart disease and metastatic prostate cancer presented with progressive neck pain and dizziness unresponsive to acetaminophen. During hospitalization he developed worsening encephalopathy, attributed to analgesics and uncontrolled hypertension; brain MRI was unremarkable. He was discharged with plans to follow up with neurology.

He was readmitted after two falls and severe hypertension, then discharged again after medication adjustments. Two days later he returned with hypotension and confusion, thought to be due to polypharmacy. A fourth hospitalization followed for hypotension during physical therapy; orthostatic hypotension was diagnosed, and

his physical therapy evaluation noted difficulty maintaining upright posture. He was discharged to different rehab facility.

Over the next four weeks he made minimal functional progress, requiring two-person assistance to stand. At a geriatric assessment visit, exam showed rigidity, masked facies, decreased proximal strength, and postural instability. He could not complete cognitive testing. Based on autonomic instability, progressive motor changes, and cognitive decline, he was diagnosed with MSA, later confirmed by his neurologist.

Discussion: The patient's neck pain, labile blood pressures, cognitive decline, and impaired motor function were all manifestations of MSA. Antecollis from cervical dystonia can cause neck pain, especially with underlying spondylosis. Severe orthostatic hypotension combined with postural abnormalities strongly suggests MSA. Although his decline seemed rapid, subtle symptoms had been present for years and were fragmented across multiple encounters, delaying diagnosis.

Conclusion: While Parkinson's disease is relatively common, MSA is rare and easily missed. Clinicians across care settings should recognize key movement disorder findings and understand their relationship to autonomic symptoms such as labile blood pressure.

B37 Resident Presentation

Not all agitation is dementia: A case series of polypharmacy-related agitation in patients with dementia

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Background: Agitation is common among nursing home residents with dementia and has many potential causes. Polypharmacy, especially involving CNS-active or anticholinergic medications, is an under-recognized contributor to acute confusion and behavioral changes in older adults. Medication toxicity can mimic or worsen dementia symptoms and may resemble atypical serotonin syndrome. New agitation should always prompt a comprehensive medication review.

Case Presentations:

Case 1: A 90-year-old woman with Alzheimer's disease developed worsening agitation after a quetiapine dose reduction. She was switched to olanzapine and sertraline and later given mirtazapine for insomnia. Over several weeks she became increasingly erratic, yelling and wheeling through hallways. Hospital evaluations found no infectious or neurologic cause. After mirtazapine was stopped due to concern for serotonin syndrome, her shouting and akathisia resolved.

Case 2: A 72-year-old woman with early-onset Alzheimer's disease developed new agitation and was started on trazodone. After several weeks she began pacing frequently and stripping off her clothes. Quetiapine was tapered and olanzapine initiated, without benefit. Trazodone was discontinued due to concern for serotonin syndrome, after which her disrobing stopped, and she became easier to redirect.

Case 3: A 98-year-old woman with Alzheimer's disease developed agitation and poor sleep. Mirtazapine was added to chronic quetiapine therapy. She developed pruritus and was taking multiple daily doses of diphenhydramine. She then began yelling at staff. After stopping mirtazapine and diphenhydramine and increasing quetiapine, her itching and behavior improved.

Discussion: Management of agitation related to dementia is challenging. Recognition of atypical behaviors like pacing as akathisia and disrobing as hyperthermia can improve management. In nursing home settings, variable staffing and limited physician contact can obscure medication-related causes. Clinicians must consider all potential causes of agitation and avoid worsening symptoms by adding medications like diphenhydramine.

Conclusion: New or worsening agitation in dementia should prompt a broad differential diagnosis, with careful assessment of all medications and their adverse effects. Deprescribing is a key step and should be pursued before adding new agents.

B38

West Nile Virus Neuroinvasive Disease Accelerating Cognitive Decline in Alzheimer's Disease: A Case Report

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Background:

West Nile Virus (WNV) is the most common arboviral infection in the United States, and older adults, especially those with neurologic conditions, are at heightened risk for severe neuroinvasive disease. Presentations may be subtle and easily missed in geriatric patients because symptoms overlap with delirium and dementia. We report a case of WNV encephalitis in a 90-year-old functionally independent woman with long-standing, stable Alzheimer's disease who developed acute fever, headache, word-finding difficulty, and progressive confusion over one week, ultimately declining to profound encephalopathy despite supportive management.

Methods:

Clinical data, diagnostic studies, and neuropathologic findings were reviewed. Evaluation included neuroimaging, WNV serology, and a comprehensive autopsy assessing viral injury and coexisting neurodegenerative pathology.

Results:

Convalescent serology confirmed acute WNV infection. Autopsy showed widespread inflammation and neuronal loss, most pronounced in the posterior fossa, consistent with WNV neuroinvasive disease. Background neuropathology demonstrated advanced Alzheimer's disease with abundant amyloid plaques and neurofibrillary tangles. A second neurodegenerative proteinopathy, TDP 43opathy, was present in the hippocampus and amygdala but not the frontal cortex, confirming Limbic predominant Age related TDP 43 Encephalopathy. The combined burden of WNV encephalitis, Alzheimer's pathology, and LATE likely acted synergistically to accelerate her rapid decline. After discussion of goals of care, she was discharged home on hospice and passed away one week later.

Conclusions:

This case highlights the need for a high index of suspicion for arboviral infections in older adults with sudden neurocognitive decline, especially during mosquito season. Although about 25 percent of WNV infections are symptomatic, roughly 1 in 150 progress to severe neuroinvasive disease including meningitis, encephalitis, or paralysis. In patients with Alzheimer's disease, WNV can trigger rapid deterioration due to underlying neuropathology. The condition carries an estimated 10 percent case fatality in U.S. data. Early recognition, prompt testing, and awareness of symptom overlap with neurodegenerative disorders are essential for diagnosis, management, and counseling in geriatric care.

B39

Frozen in Confusion: Diagnostic Overlap of Catatonia, Delirium, and Severe Dementia in an Older Adult

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Background

Behavioral unresponsiveness in older adults may resemble catatonia, yet overlapping features of delirium and advanced dementia often make diagnosis difficult. Accurate differentiation is essential since management and prognosis differ markedly. Misinterpretation can lead to inappropriate sedative medication use and missed treatment opportunities including goals-of-care discussions. We report a case highlighting diagnostic complexity of catatonia like presentation and emphasizing the importance of comprehensive geriatric assessment.

Methods

A 72-year-old man with alcohol use disorder, major depressive disorder, bipolar disorder, and seizure disorder presented with mutism, posturing, and markedly reduced responsiveness. Evaluation

occurred mainly in inpatient setting. Workup included laboratory studies, MRI, EEG, medication review, and trials of sedatives. Catatonia was assessed using the Bush-Francis Catatonia Rating Scale (BFCRS). Psychiatry, Neurology, Geriatrics, and Palliative Care were consulted.

Results

BFCRS increased from 2 to 14 during hospitalization. A lorazepam challenge produced only brief relaxation without sustained benefit. Ketamine trials yielded modest, inconsistent responses. Catatonic-appearing signs included rigidity, stereotyped oral movements, staring, and gegenhalten. EEG showed moderate encephalopathy without epileptiform activity. MRI demonstrated severe cerebral atrophy concerning for an underlying neurodegenerative process. Family reported longstanding cognitive decline, mood variability, psychotic symptoms, and dependence for all ADLs and IADLs. A concurrent urinary tract infection and fluctuating alertness suggested superimposed hypoactive delirium. After multidisciplinary review, the presentation was judged most consistent with advanced neurocognitive disorder complicated by delirium, with catatonic features viewed as secondary rather than primary.

Conclusions

This case emphasizes the substantial overlap among catatonia, delirium, and severe dementia in older adults. Recognition of this interplay can prevent unnecessary psychotropic exposure and promote more appropriate, person-centered care planning. The case also underscores the importance of early geriatric assessment, ideally initiated in outpatient settings, and the need for greater awareness among providers when evaluating acute behavioral or mental status changes in aging populations.

B40

Insulinoma in a Frail Older Adult

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Insulinoma is a rare neuroendocrine tumor causing recurrent hypoglycemia, and decision-making becomes more complex in frail older adults due to procedural risk and multimorbidity. We present the case of an 89-year-old woman with recurrent hypoglycemia and a small pancreatic lesion suspicious for insulinoma. Her course was complicated by *C. difficile* colitis and SIADH, prompting multidisciplinary review of diagnostic and therapeutic options. EUS-guided biopsy was deferred due to anesthesia risk and low diagnostic yield, and octreotide improved glucose stability. Palliative care discussions aligned treatment with her goals of returning home and avoiding invasive procedures, emphasizing the need to balance diagnostic certainty, safety, and patient-centered priorities.

Background

Insulinoma is an uncommon pancreatic neuroendocrine tumor that causes endogenous hyperinsulinemic hypoglycemia. Although surgery is definitive therapy, older adults with frailty and multimorbidity face higher procedural risk. Diagnostic evaluation and treatment must therefore be weighed carefully to avoid harm and maintain quality of life.

Case

An 89-year-old woman with atrial fibrillation, hypertension, chronic kidney disease, and osteoporosis presented with confusion and slurred speech and was found to have recurrent hypoglycemia. Labs showed elevated insulin, C-peptide, and proinsulin with suppressed beta-hydroxybutyrate. CT imaging revealed a 0.8-cm enhancing pancreatic neck lesion. Her hospitalization was complicated by *C. difficile* colitis and SIADH. Multidisciplinary review considered EUS-guided biopsy but avoided it because of frailty, anesthesia risk, and low likelihood of altering management. Diazoxide was discussed but avoided due to concerns about fluid retention and hematologic toxicity. Octreotide was initiated with improved glucose stability. Palliative care supported goals-of-care discussions; she prioritized returning home and avoiding burdensome procedures, with openness to hospice if her condition declined.

Discussion/conclusion

This case highlights the complexity of managing suspected insulinoma in a frail older adult. Although imaging and labs supported the diagnosis, the risks of invasive testing outweighed potential benefit given her comorbidities and poor surgical candidacy. Management focused on symptom control with octreotide and alignment of care with her goals. In frail older adults, a conservative, patient-centered approach may be more appropriate when the burdens of intervention exceed likely benefit.

B41

Geriatric depression or readiness for death? When are we allowed to die?

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Background

An appropriate readiness for death mindset is commonly confounded by superimposed depression brought on by serious illness. Both influence the patient's will to engage in treatment, which affects prognosis (1). For our oldest patients that have long reported a healthy readiness for death, we ask ourselves whether treating situational depression in hopes of patient engagement in treatment to improve prognosis contradicts their longer standing preparedness for death.

Case Description

Mrs. Davis is an active, fiercely independent, community dwelling centenarian presenting after a fall that underwent an uncomplicated hip fracture repair. Palliative care was consulted after the patient woke up in the ICU yelling at her family to "just let me die, I have been ready for so long." Pain, delirium, and metabolic disturbances were ruled out, yet she continued repeating "just let me go," and took minimal oral intake. Careful spiritual and palliative assessments revealed an enduring, appropriate readiness for death without suicidal ideation, but also recent depressive symptoms centered around the loss of close friends and independence. Despite a successful surgery, she faced an up to 50% one-year post-op mortality, and a protracted recovery course with an uncertain ability to regain her prized independence. Her already slim chance of protecting this core value was further whittled by her neurovegetative symptoms and readiness for death, both draining her will to fight. Through interdisciplinary discussions with the patient, duloxetine was started. She transitioned to DNR/DNI and was discharged to rehab for an attempt to regain her independence, with the plan to move to hospice if and when she determined she had tried enough. This approach afforded her the best chance for regaining her physical independence, while giving her the spiritual agency to decide when enough is enough.

B42 Resident Presentation

Statin-Induced Immune-Mediated Necrotizing Myopathy Presenting With Progressive Proximal Weakness and Elevated Transaminases

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Immune-mediated necrotizing myopathy (IMNM) is a rare myopathy characterized by subacute or chronic progressive proximal muscle weakness with markedly elevated creatine kinase (CK), commonly associated with anti-HMG CoA reductase antibodies. Unlike statin-related myalgias, IMNM does not improve with statin discontinuation and requires immunosuppressive therapy.

We present a 74-year-old man with seizure disorder, iron deficiency anemia, and ischemic stroke six months prior who developed several weeks of worsening lower extremity weakness and recurrent falls, initially attributed to deconditioning or possible stroke recurrence. He had recently been hospitalized for elevated transaminases presumed drug-induced, leading to discontinuation of his statin, lisinopril, oxcabazepine, and sertraline without improvement. On presentation, he

was hemodynamically stable. Neurologic examination showed marked proximal weakness (3/5 bilateral shoulder abduction; 2/5 hip flexion) with preserved distal strength.

Laboratory evaluation revealed persistent transaminase elevation (AST 412 U/L, ALT 475 U/L, normal alkaline phosphatase) and newly elevated CK of 8,800 U/L. Inflammatory markers were only mildly elevated. A comprehensive myositis panel (MyoMarker 3) was negative, including anti-Jo-1 and anti-SRP, though it did not include HMG CoA reductase antibodies. MRI of the lower extremities demonstrated diffuse bilateral muscle edema involving the hamstrings and quadriceps with mild atrophy and fatty infiltration. Electromyography confirmed a primary subacute myopathic process. Anti-HMG CoA reductase antibody returned markedly positive at 289 CU, confirming statin-associated IMNM. Muscle biopsy was deferred given high diagnostic certainty.

The patient was treated with high-dose corticosteroids followed by monthly outpatient IVIG. CK declined to <5,000 U/L before discharge, and both CK and transaminases normalized within one month. With supportive rehabilitation, his proximal weakness gradually improved. He continues IVIG therapy and avoids statin use.

This case emphasizes the importance of recognizing IMNM in patients presenting with progressive proximal weakness and transaminitis, even after statin discontinuation. Early diagnosis and initiation of immunosuppressive therapy plus physical rehabilitation are essential to prevent further long-term functional decline.

B43 Resident Presentation

One Skin Biopsy Away from the Correct Diagnosis

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Background

Skin conditions in older adults are frequently complicated by age-related changes that reduce cutaneous integrity and adequate healing. They often present with nonspecific clinical features, making diagnosis difficult based solely on examination. Infections, inflammatory, and autoimmune dermatoses can mimic one another, leading to delayed appropriate treatment. Skin biopsy remains the cornerstone diagnostic tool in dermatology, with reported accuracy of 80-97%. Early consideration of biopsy is especially valuable in older adults, as it can significantly improve patient outcomes by providing a precise diagnosis and timely intervention.

Methods

We describe two diagnostically challenging dermatoses in which skin biopsy was essential for clarifying the diagnosis and guiding treatment.

Results

Case 1: 78-year-old Mandarin-speaking Chinese woman, with hypertension and type 2 diabetes, presented with acute sore throat, cough, fever, and generalized pruritic erythematous rash. Exam showed oropharyngeal erythema and multiple well-defined circular erythematous skin lesions. Although she was initially treated for varicella, an extensive workup suggested an infectious etiology was less likely. Skin biopsy revealed vacuolar interface dermatitis, consistent with erythema multiforme. She improved with systemic and topical corticosteroids.

Case 2: 64-year-old woman with diabetes, hypertension, peripheral artery disease, IgA-mediated leukocytoclastic vasculitis, and a functional geriatric vulnerability profile (impaired wound healing, profound deafness requiring exclusive sign language communication), had chronic thigh nonhealing ulcers from a dog bite with intermittent superinfections. She now presented with new erythematous pruritic papules on the thighs and worsening ulcer pain. She was initially treated for presumed superinfected skin lesions without response. Skin biopsy revealed scabies, and targeted therapy with ivermectin, permethrin, and topical corticosteroids resulted in complete resolution.

Conclusion

These two cases highlight the diagnostic challenges of dermatoses in older adults, especially when geriatric vulnerability factors are present. Skin biopsy provides important histopathologic information needed to clarify the diagnosis. It is a minimally invasive tool that changes management in up to 70% of cases, improves clinical outcomes, reduces unnecessary antimicrobial use, and shortens diagnostic delays.

B44 Resident Presentation

Beyond Revascularization: Patient-Centered Management of Acute Limb Ischemia in a Frail Older Adult

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Background

Acute limb ischemia is a life-threatening emergency that disproportionately affects older adults. More than half of cases occur in patients older than seventy-five years, and mortality increases sharply in those eighty-five years and older. Frailty, multimorbidity, and limited physiologic reserve often make the risks of revascularization higher than the expected benefit. Because guidelines offer limited direction for conservative management in the oldest old adults who are not fit for surgical management, shared decision-making is essential.

Methods

We present the case of a nonagenarian with acute limb ischemia managed conservatively to illustrate risk-benefit assessment and patient-centered decision making in the oldest old.

Results

97-year-old woman with atrial fibrillation on anticoagulation, heart failure with reduced ejection fraction, hypertension, and limited mobility reported 2 days of left lower extremity pain and weakness. Exam showed coolness and discoloration of the first toe and absent dorsalis pedis pulse. Ankle brachial index was 0.31. Imaging and Doppler confirmed acute occlusion of the mid superficial femoral and anterior tibial arteries, consistent with Rutherford IIb. Although this degree of ischemia typically prompts urgent revascularization, her extreme age, frailty, and cardiac disease predicted very high perioperative mortality. Through structured shared decision making, the risks, benefits, and alternatives were reviewed. The patient prioritized avoiding major surgery and maintaining her current level of function. She was treated with intravenous heparin. Pain, color, and perfusion improved, with return of distal Doppler signals. She was discharged on aspirin and apixaban, avoiding dual antiplatelet therapy due to bleeding risk, and received physical therapy to support mobility.

Discussion/conclusion:

Studies show significantly higher death and complication rates after infrainguinal revascularization in adults older than 80 years, and amputation-free survival is often limited by competing mortality. For the oldest old adults, management of acute limb ischemia must integrate frailty, comorbidity, life expectancy, and patient goals rather than defaulting to revascularization. Conservative therapy with anticoagulation is a reasonable, guideline-supported option when procedural risk is prohibitive, and the patient prefers noninvasive care.

B45

Compression With Choice: How Underused Lymphedema Pumps Restore Patient Autonomy

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Background: Venous leg ulcers are chronic, shallow, irregular wounds that develop when dysfunctional venous valves cause sustained venous hypertension, leading to edema, inflammation, and impaired tissue nutrition. They typically occur around the medial ankle and heal slowly without targeted compression therapy. Chronic venous hypertension not only impairs venous return but eventually overwhelms the lymphatic system, creating persistent, protein-rich

edema, leading to phlebolymphe­dema. Phlebolymphe­dema is present in the majority of patients with venous leg ulcers, though it remains widely under­recognized in clinical practice. Lymphhe­dema pumps can offer an often-desired alternative to multi-layer compression or Unna boots.

Case: An 87 yo ambulatory woman presented with ulceration of her right shin since 11/2024. She was treated at OSH with silver alginate and Unna boot from 3/2025-7/2025 without much improvement in the ulcer. She declined biopsy, was tired of wearing an Unna boot without results, and was therefore switched to silver alginate, silicone foam border dressing, and elasticated tubular bandage (~8-10 mmHg). She changed care to the Wound Healing Clinic at Mount Sinai starting 10/2025 feeling frustrated that no other treatments had been offered. Lymphhe­dema pumps were ordered at first visit and started shortly after (typical treatment time 60 minutes per day), with significant improvement of her edema and subjectively improved quality of life. She continued wearing the elasticated tubular bandage. Bovine derived collagen matrix was added 11/2025. At most recent follow-up, her wound has almost fully healed.

Conclusions: As providers, we have a responsibility to listen to our patients—understanding their goals, their barriers, and what matters most in their daily lives. Empowering autonomy means offering treatment options that support independence, and lymphhe­dema pumps are an underutilized tool that can do exactly that. By incorporating these devices more frequently into care plans, we not only enhance clinical outcomes for venous disease and chronic edema but also give patients greater control over their healing process.

B46

When Altered Mental Status Defies the Algorithm: A Rapidly Progressive Encephalopathy Revealing Creutzfeldt Jakob Disease
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Background

Altered mental status in older adults often reflects overlapping metabolic, infectious, or neurologic processes. Early imaging of CSF may be nondiagnostic, delaying recognition of rapidly progressive conditions such as Creutzfeldt Jakob Disease (CJD). This case highlights prolonged diagnostic uncertainty despite extensive testing and demonstrates how serial imaging ultimately clarified etiology.

Case Description

A 69-year-old man with JAK2-positive essential thrombocy-tosis, polycythemia vera, cirrhosis from treated hepatitis C, chronic leukocytosis, and prior stroke presented with headache, neck and abdominal pain, and abrupt confusion, declining from fully oriented to severely impaired within days. Differential included meningitis, cirrhosis-related encephalopathy, medication effects, myeloprolifera-tive disease, and prior stroke, yet none explained rapid progression. Initial CT, MRI, and MRV brain were unrevealing. Extensive infec-tious, metabolic, autoimmune, toxic, and paraneoplastic evaluation including herpesvirus PCRs, HIV, RPR, thyroid studies, autoimmune panels, heavy metal screening, metabolic workup, CSF studies, and EEG remained unrevealing. He received lactulose for possible hepatic encephalopathy and later high-dose steroids and IVIG for presumed autoimmune encephalitis without improvement.

Diagnostic breakthrough occurred on hospital day 34 when repeat MRI showed new symmetric restricted diffusion in the caudate nuclei, which is classic for CJD. Repeat CSF including RT-QuIC was noncon-firmatory, but evolving MRI combined with persistently negative broad evaluation made CJD most likely. Once the diagnosis was clarified, goals-of-care discussions and transition to hospice were initiated.

Discussion

This case illustrates how early CJD can mimic infectious, auto-immune, and metabolic etiologies, and how serial imaging may offer clues.

Conclusion

In older adults with rapidly progressive encephalopathy and nondiagnostic early studies, CJD should remain in consideration. Persistent reassessment and serial neuroimaging are essential for uncovering prion disease and guiding timely goals-of-care decisions.

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B47 Student Presentation

A Stroke Impersonator: Atypical Presentation of Nocardia Brain Abscess

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Background: *Nocardia* species are aerobic, filamentous bacteria that rarely cause human disease but can lead to severe opportunistic infections in immunocompromised hosts. Central nervous system (CNS) nocardiosis accounts for about 2% of all brain abscesses yet carries mortality rates exceeding 30%. This case report describes the presentation, diagnosis, and management of a nocardial brain abscess in an immunocompromised patient to highlight diagnostic challenges and therapeutic considerations.

Methods: We conducted a case study at a tertiary academic hospi-tal. Clinical data were reviewed from the electronic medical record.

Results: A 70-year-old Caucasian female with chronic kidney disease, diabetes, and cryoglobulinemic membranoproliferative glomerulonephritis on corticosteroids and rituximab presented with subacute right-sided headache and left visual field loss. CT showed right occipital edema and MRI demonstrated a 3.3 cm ring-enhancing occipital mass with restricted diffusion. Craniotomy and drainage yielded purulent material which was sent for culture. Empiric vancomycin, ceftriaxone, and metronidazole were transi-tioned to high-dose trimethoprim-sulfamethoxazole and imipenem after cultures grew *Nocardia* species, later changed to linezolid and imipenem due to nephrotoxicity. Postoperatively, the patient's visual symptoms stabilized and repeat MRI showed marked reduc-tion in abscess size and edema. She began long-term combination antibiotic therapy with clinical improvement and no recurrence on follow-up imaging.

Conclusions: CNS nocardiosis can easily be misattributed to a vascular event or general mass effect. Typically, pulmonary involvement or fever would raise suspicion for *Nocardia* infec-tion. However, our patient presented primarily with nonspecific CNS symptoms of headache and visual disturbance which were more concerning for stroke given her risk factors. Therefore, nocardiosis should be considered in immunocompromised patients presenting with CNS symptoms even in the absence of pulmonary disease. MRI with diffusion-weighted sequences facilitates early recognition, and diagnosis requires microbiologic confirmation of the abscess. Optimal management includes surgical drainage and prolonged targeted antibiotic therapy guided by renal func-tion and susceptibility results. Heightened clinical suspicion and early multidisciplinary management can improve outcomes in this high-mortality infection.

B48

A Diagnosis of Hemophagocytic Lymphohistiocytosis in an Older Patient: What do we do now?

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Background:

Hemophagocytic lymphohistiocytosis (HLH) is a rare, life-threatening syndrome marked by immune overactivation, cytopenias, and progressive organ failure. Diagnosis in older adults is challenging due to comorbidities and polypharmacy often mimic infection or malignancy. Prognostication becomes difficult when no trigger is found, requiring assessment of frailty, physiologic reserve, and patient goals.

Case Description:

An 88-year-old widowed man with coronary artery disease, prostate cancer on surveillance, and recent bereavement presented with failure to thrive and recurrent fevers. Evaluation showed cytopenias, elevated LDH, hyperferritinemia, and hepatosplenomegaly. Soluble CD25 was elevated (>41,000), supporting HLH. Bone marrow biopsy did not reveal malignancy, hemophagocytosis, or underlying driver.

His course progressed to encephalopathy, respiratory failure, and multi-organ dysfunction. The team used the 4Ms framework ("What Matters Most, Mentation, Mobility, Medications") to guide disease and patient centered prognostication with his family. Delirium with dysphagia limited his nutrition. He became non-ambulatory status, indicating poor rehabilitation potential. Rising polypharmacy increased risk of treatment with minimal expected benefit. What mattered most to him was independence, mobility, and quality of life. Given his frailty, profound decline, and low likelihood of recovery, the family chose comfort care.

Discussion:

Adult HLH has a mortality of 50–60%, with worse outcomes in older adults. Prognosis depends on etiology, organ dysfunction, and treatment response. When no trigger is identified, empiric immunosuppression carries uncertain benefit and significant toxicity. Tools such as the Sequential Organ Failure Assessment and Palliative Performance Scale provide context but must be combined with frailty and functional assessments. Early geriatric-palliative involvement and structured approaches like the 4Ms help align treatment with patient values.

Conclusions:

This case highlights frail patients without an identifiable underlying driver of HLH, individualized prognostication and shared decision-making support that prioritizes dignity, comfort, and personal values promotes optimal patient care.

B49 Student Presentation

A rare case of pemphigus vulgaris in a nonagenarian

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Background: Pemphigus vulgaris (PV) is an autoimmune blistering disease of anti-desmoglein IgG autoantibodies resulting in painful erosions of the skin and mucus membranes. It affects both genders equally with mean onset at 50–60 years of age. PV rarely involves the esophagus¹ and to our knowledge there are only 2 other reports of PV in nonagenarians^{2,3}.

Case: A 94-year-old male with past medical history of PV for 1.5 years presented to the ED with worsening skin, oral lesions, and purulent eye drainage a month after stopping mycophenolate mofetil due to brain fog. He was treated with high dose steroids, mycophenolate mofetil, IVIG, rituximab, and GI prophylaxis with PPI. Dexamethasone swish and spit elixir was used for oral lesions and dressings changed

daily on the eroded areas. Lesions showed improvement, but the patient's condition deteriorated rapidly with onset of a brisk upper GI bleed causing fatal hemorrhagic shock. Death was attributable to PV based on direct immunofluorescence of esophageal ulcer.

Discussion: This case demonstrates the importance of the 4Ms. The patient discontinued his mycophenolate mofetil due to the unacceptable side effect of confusion. The patient's priority was his **mentation**, so delirium precautions were emphasized in his care. Early taper of high dose steroids was a goal due to delirium risk; however, these **medications** could not be deprescribed given the extent of his PV. Ultimately, identifying **what matters** to the patient became very important for determining his resuscitation status.

Conclusion: This report presents a unique case of PV with esophageal involvement in a nonagenarian, the only report of its kind based on extensive literature review.

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B50 Resident Presentation

"The Diagnostic Dilemma of Alzheimer's Disease: A Case of Diagnostic Biomarker Discordance"

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Introduction:

Alzheimer's disease (AD) is the most common dementia. Biomarkers such as structural MRI, FDG-PET, amyloid PET, and cerebrospinal fluid (CSF) measures play key roles in diagnosis and monitoring. We describe a case of AD with notable biomarker discordance.

Case:

An 81-year-old Caucasian woman presented in 2014 with a two-year history of short-term memory decline while remaining independent in all ADLs. Physical and neurological exams were unremarkable. Family history included dementia in her mother, aunt, and uncle. Neuropsychological testing showed single-domain non-amnesic mild cognitive impairment (MCI) with executive dysfunction. MRI revealed an incidental internal carotid artery aneurysm, later treated with coiling. FDG-PET in 2015 showed bilateral anterior temporal hypometabolism with borderline medial frontal involvement. Volumetric analysis demonstrated hippocampal atrophy and enlarged inferior lateral ventricles compared to age- and sex-matched peers. By 2021, she reported progressive memory decline. Repeat volumetrics showed further hippocampal atrophy with ventricular enlargement. CSF analysis demonstrated elevated amyloid-β42 (1280 pg/mL), total tau, and phosphorylated tau, interpreted as non-AD pathologic change due to the abnormal amyloid-β42 ratio. However, amyloid PET imaging showed clear cortical amyloid plaque deposition, supporting a high-probability diagnosis of Alzheimer's disease.

Conclusion:

This case highlights the diagnostic challenges of Alzheimer's disease when biomarkers are discordant. Positive amyloid PET may strongly support AD even when CSF amyloid-β42 appears paradoxically elevated, reflecting variability in disease stage, assay sensitivity, or preanalytical factors. According to the National Institute on Aging–Alzheimer's Association (NIA-AA) framework, integrating clinical

findings with multimodal biomarkers improves diagnostic accuracy. Because biomarker discordance occurs in up to 15% of individuals, recognizing these discrepancies is essential for accurate diagnosis, clinical trial eligibility, and care planning in Alzheimer's disease.

B51

Rapidly Progressive Mixed Alzheimer and Dementia with Lewy Bodies: A Clinicopathologic Case Report

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Background: Mixed Alzheimer's disease (AD) and Dementia with Lewy Bodies (DLB) can be difficult to recognize early, particularly when progression is unusually rapid. This case highlights a steep decline from mild cognitive impairment (MCI) to death, resulting from end-stage dementia in under three years, confirmed by autopsy.

Methods: Retrospective review of evaluations from 2022–2025, including serial neuropsychological testing (NPT), MRI, CSF biomarkers, dopamine transporter (DaT) scan, functional assessments, and postmortem neuropathology.

Results: In 2022, a 72-year-old woman with clinical evaluation and NPT demonstrating non-amnesic, dysexecutive MCI, developed progressive anomia. Examination showed resting tremor, right-sided rigidity, and reduced arm swing. Brain MRI revealed moderate white matter disease, preserved medial temporal lobe volumes, and subtle loss of the left substantia nigra "swallow-tail" sign. CSF biomarkers showed elevated P-tau/A β 42 ratio (0.027), consistent with AD biological diagnosis, with no infectious or autoimmune abnormalities. DaT scan showed bilaterally reduced putaminal uptake, consistent with loss of dopamine transporters. By mid-2023, NPT showed further cognitive decline and new dependence in financial management and driving, meeting criteria for mild dementia. By 2024, she developed non-disturbing vivid visual hallucinations. Despite symptomatic treatment with standard AD and parkinsonian therapies, she had rapid cognitive and functional decline and required assistance with most ADLs by late 2024. She was hospitalized in early 2025 with acute encephalopathy, aspiration pneumonitis, transitioned to comfort care, died two weeks later. Postmortem examination revealed Thal stage 3 amyloid plaques, Braak stage V neurofibrillary tangles, widespread cortical and limbic α -synuclein-positive Lewy bodies (Braak Stage III), confirming mixed AD and DLB pathology.

Conclusions: This case illustrates how combined AD and DLB pathology can drive an accelerated clinical course marked by early dysexecutive deficits, emerging parkinsonism, and rapid cognitive and functional decline. Recognition of mixed pathology is essential when older adults present with atypically fast progression. Multimodal biomarkers and longitudinal assessment support diagnosis and counseling.

B52 Student Presentation

Challenges for Older Veterans in Disaster-Prone Rural Areas

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Older adults in rural, disaster-prone regions face significant barriers to healthcare access. Veterans Affairs (VA) Home-Based Primary Care (HBPC) aims to address these gaps, yet recurrent coastal flooding can impede home visits and service continuity. This case explores the impact of environmental barriers on HBPC delivery for older rural veterans.

Methods: A descriptive case study was conducted involving a 95-year-old veteran enrolled in VA HBPC, residing in a flood-prone coastal Delaware community. Data were abstracted from

interdisciplinary HBPC documentation, including functional assessments, comorbidity profiles, and service utilization.

Results: The veteran lived alone with limited support, relied on his son for transportation and certain instrumental activities, and received community nutrition services. However, access to nutrition was unreliable; Meals on Wheels deliveries were often unusable due to coastal flooding, with no alternative programs available in his location. Issues concerning weight loss and potential dehydration were recurrent. Medication access was also inconsistent; the veteran struggled with mail-order prescriptions with inconsistent refills, complicating chronic disease management. He remained independent in basic activities of daily living but had extensive multimorbidity, ranging from cardiovascular, musculoskeletal, nutritional, and psychiatric conditions.

Functional evaluations indicated moderate frailty and elevated risks of falls and nutritional deficiencies (Palliative Performance Scale 60%, MAHC-10 score 9), with a Braden score of 20 indicating low pressure-injury risk. Interdisciplinary notes highlighted strained caregiver dynamics, and the inability to secure in-home personal care due to county and agency limitations, as well as challenges in coordinating non-VA services in a disaster-prone region. Goals-of-care discussions showed intact decision-making capacity and the veteran's strong preference to remain at home while avoiding burdensome interventions despite increasing needs.

Conclusions: In disaster-prone rural environments, current VA HBPC models may be insufficient for older veterans with complex conditions and limited support. Enhanced home health strategies, including telehealth, mobile care units, and disaster-resilient planning, may strengthen care continuity and outcomes for this vulnerable population.

B53

Immune checkpoint inhibitor-induced myocarditis with severe aortic stenosis: a double whammy dilemma

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The coexistence of age-related valvular degeneration and cardiotoxicity from oncologic therapy can obscure the clinical presentation in geriatric populations. Accurate diagnosis requires recognition of these concurrent pathologies and identification of the dominant contributor to the patient's presentation.

A 75-year-old male with severe aortic stenosis, HFrEF, COPD, type 2 diabetes, and metastatic non-small cell lung carcinoma treated with pembrolizumab (complicated by pneumonitis) was admitted to the ICU with respiratory failure and septic shock secondary to aspiration pneumonia. His clinical course was complicated by pulmonary edema from decompensated heart failure. In the hospital, he had a chest pain with markedly elevated troponin levels exceeding 50,000 ng/L and nonspecific ST-segment changes on EKG. A coronary angiography was planned. He subsequently developed hypotension requiring vasopressor support. Given his recent pembrolizumab therapy and the degree of troponin elevation, pulse-dose intravenous steroid was added for presumed immune-mediated myocarditis.

The patient showed clinical response to steroid therapy, with progressive decline in serial troponin measurements. He was successfully weaned from vasopressor support after three days of steroid treatment, and his oxygen requirements also improved. Following extensive discussions with the patient and his family regarding his overall prognosis and goals of care, the decision was made to transition to hospice care.

Despite its low incidence of approximately 0.06%, checkpoint inhibitor-associated myocarditis constitutes one of the most fatal immune-related adverse effects of immunotherapy and may evade

diagnosis without appropriate clinical vigilance. The pathophysiology involves an autoimmune mechanism whereby activated T lymphocytes target myocardial and conduction tissue.¹ A high level of clinical vigilance for checkpoint inhibitor-associated myocarditis in all patients receiving immunotherapy is paramount, as diagnosis mandates urgent initiation of pulse-dose intravenous corticosteroid therapy and irreversible termination of the offending agent.²

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B54 Student Presentation

ARIA-E Mimicking Occipital Stroke Following First Lecanemab Infusion

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Lecanemab is an FDA-approved monoclonal antibody treatment for early Alzheimer's disease that targets and removes amyloid plaques from the brain. A serious side effect is amyloid-related imaging abnormalities (ARIA), which includes ARIA-E (edema) and ARIA-H (microhemorrhage or hemosiderin deposition). About 12% of patients on lecanemab experience ARIA-E, but only 2.8% of patients present symptomatically.¹ Risk factors for developing ARIA-E include increased severity of dementia, higher treatment dose, and more than four pre-existing microhemorrhages. Within these cases, the most commonly reported symptoms included headache, visual disturbance, and confusion.¹

We describe a 78-year-old woman with mild cognitive impairment from Alzheimer's disease and other comorbidities, including high blood pressure, common variable immunodeficiency, and breast cancer. After discussion with the treatment team of potential benefits, risk factors (including ApoE e4 heterozygosity and two pre-existing microhemorrhages), and alternative treatment options, the decision was made to proceed with lecanemab infusions.

Days after her first infusion, she presented to the ED with occipital stroke-like symptoms and a hypertensive emergency attributed to severe ARIA-E discovered on her brain MRI. She was admitted to the ICU, and her symptoms improved after high-dose intravenous methylprednisolone and lisinopril. A repeat brain MRI showed markedly improved edema contrast-enhancement without new hemosiderin deposition. The patient stopped treatment with Lecanemab infusions and returned to her baseline over the following month.

Although the patient had risk factors, it's unclear why she had a severe case of ARIA-E after just one infusion. This case highlights that while ARIA-E can present suddenly and resemble a stroke, patients also can respond well to the empirically recommended treatment of high-dose steroids. Establishing strong evidence for the efficacy of this treatment is critical to developing formal guidelines for treatment of ARIA-E. A brain MRI remains the best way to assess ARIA and monitor resolution.

1. van Dyck CH, Swanson CJ, Aisen P, et al. Lecanemab in Early Alzheimer's Disease. *New England Journal of Medicine*. 2023;388(1):9-21. doi:10.1056/NEJMoa2212948

B55 Encore Presentation

Intersection Navigation and Speed Patterns on Familiar Routes Differentiate Older Drivers with Mild Cognitive Impairment

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Background:

Most collisions among older drivers occur close to home, where routes are familiar. While familiarity can reduce cognitive demand, it may also reduce attention and increase reliance on habits. This study examines whether older adults with mild cognitive impairment (MCI) can be distinguished from healthy controls (CTL) based on real-world driving behaviours on their most frequently traveled routes.

Methods:

Naturalistic driving data was collected over eight weeks using an in-vehicle Driving Monitoring System (DMS) from 21 older drivers (13 CTL, 8 MCI) in Calgary (n=13) and Toronto (n=8). The DMS continuously captured GPS and inertial sensor data. Each participant's most familiar route was identified using a clustering technique, selecting the cluster with the highest trip count. Eleven driving features were extracted: (1-2) count and percentage of time speeding ($\geq 10\%$ above limit), (3-4) count and percentage of time driving below limit ($\leq 80\%$), (5) sudden acceleration events, (6) sudden braking events, (7) average trip length, (8-10) intersection speeds when driving through, slowing, or stopping, and (11) overall average intersection speed. The model included sex and study site. An XGBoost model classified trips as MCI or CTL using 80% of participants for training and 20% for testing. Performance metrics included sensitivity, specificity, accuracy, and AUC. Feature importance was computed.

Results:

Across 21 drivers (12 women, 9 men), 143 familiar-route trips (84 CTL, 59 MCI) were analyzed. The model achieved an AUC of 0.79 and accuracy of 0.73. Sensitivity was high (92%) while specificity was lower (46%). Top features were sex, site, intersection speed when driving through, trip length, and rate of sudden braking per kilometer.

Conclusion:

This early analysis suggests that driving behaviours on familiar routes, which exhibit high sensitivity, may help identify older adults with possible MCI. Future studies are needed to improve specificity and further validate these findings.

B56

Striking GOLD: An Interprofessional Geriatrics Pilot for Older Adults Experiencing Homelessness

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Background: Older adults are the fastest-growing group experiencing homelessness and although geriatric syndromes are well documented in this population, supports often fall away as needs intensify. To address this gap, we piloted an interprofessional geriatrics team embedded within a homeless healthcare organization.

Methods: In June 2024, the interprofessional team launched within the homeless healthcare program. Providers referred older adults for challenges with self-care, multimorbidity, polypharmacy, rising hospital use, loss of case-management eligibility, or concerns for frailty or cognitive decline. Based on referral indications, patients received either a focused nursing and case-management intake or a comprehensive geriatric assessment by a geriatrician. Then based on discovered

needs, patients were provided a one-time consultation or longitudinal geriatrics care across clinic, shelter, hospital, and street settings.

Results: Thirty-four patients enrolled; 30 were included in 90-day pre-post observational analyses. Most were aged 65–74 (91%), male (73%), English-speaking (82%), and identified as Black/African American (48%). At enrollment, 58% lived in supportive or permanent housing and 42% were unhoused. Geriatric syndromes were common including depression (73.5%), incontinence (20.6%), falls (23.4%), polypharmacy (100%, averaging 17.9 medications), and cognitive impairment (8.8%). Excluding one outlier, in the 90-days prior to enrollment, participants averaged 0.7 ED visits and 0.63 inpatient admissions. Post-enrollment, ED visits rose to 1.56 while inpatient admissions declined to 0.43—a 32% reduction.

Conclusions: This interprofessional model highlights the critical need for geriatric expertise within homeless healthcare. Early findings show substantial medical complexity, and enrollment was associated with reduced hospital admissions. Future studies should assess long-term outcomes and identify the patient characteristics that maximize impact.

B57

Geriatric Assessment in an Interdisciplinary HIV Clinic

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Background: People living with HIV over 50 years old (PLWH 50+) have an increased burden of geriatric syndromes that are not fully addressed by traditional HIV care models. To better meet these needs, we implemented a geriatrician-led interdisciplinary team within an HIV primary care clinic (Geri-HIV), aimed at increasing recognition and management of geriatric vulnerabilities via comprehensive geriatric assessments.

Methods: We performed a retrospective electronic medical record chart review of PLWH 50+ who received an initial geriatric evaluation over a 9-month period (Dec 1, 2023 to Aug 31, 2024). Data collected included geriatric screen results and completion rates and corresponding recommendations.

Results: Of the 38 patients evaluated, the average age was 67 (SD 8) years; 76% were male, 29% White, 43% Hispanic, and 25% Black. 100% of patients had a suppressed viral load; 5% had CD4 count <200. Geriatric screening completion rates were high: 100% for falls, 97% for ADLs (Katz) and IADLs (Lawton), 76% for frailty (FRAIL scale), and 100% for mood (PHQ4). Depression and anxiety (39% with positive PHQ4, average PHQ9 of 12.8 and GAD7 of 11.7) and frailty (54% prefrail, 34% frail) were prevalent. Average ADL score was 20.6 and iADL was 20.7, indicating dependence.

“Mind” was the most common reason for referral; of these referrals, 91% were screened for cognitive impairment. In those screened with MoCA (N=19), the average score was 21.2. 61% of patients referred for cognitive evaluation received a new diagnosis of mild cognitive impairment or dementia at intake visit and 83% received counseling on cognitive dysfunction.

Conclusions: The integrated Geri-HIV model enabled high rates of geriatric assessment completion in PLWH 50+ after a single visit. Most patients demonstrated at least one major abnormality within the 5M framework, prompting targeted interventions. Importantly, this program facilitates early identification of cognitive impairment, allowing for timely intervention and connection to supportive resources. As such, it offers a scalable approach to advancing age-friendly care for this population.

B58 Student Presentation

Evolution of Personal Values in Women with Metastatic Breast Cancer

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Background: Women living with metastatic breast cancer (mBC) face persistent uncertainty and must navigate nuanced decisions about treatment, symptom management, and quality-of-life tradeoffs. However, clinical conversations rarely revisit what matters most to patients outside of formal goals-of-care discussions. To address this gap, the Values Assessment Tool (VaST) was co-designed with women with mBC to facilitate ongoing reflection. This study explored how women’s values evolved over a brief treatment period and examined the ways these value shifts were expressed during oncology encounters.

Methods: This three-month mixed-methods study enrolled 30 adult women with mBC receiving outpatient oncology care. Participants completed repeated VaST rankings before clinic visits, baseline surveys, and an end-of-study interview. Clinical encounters were audio-recorded and analyzed using thematic analysis. The primary aim of this analysis was to examine how values changed over time and how clinicians engaged with these shifts. This preliminary analysis is based on data from the first four participants, each of whom completed 4 VaST surveys during their enrollment.

Results: Preliminary qualitative findings revealed that shifts in values were often driven by daily realities, such as caregiving demands or acute infections, rather than by changes in disease status. For example, participants who identified “living to care for a loved one” as a top priority showed remarkable stability in that value over time. In contrast, a participant managing recurrent C. difficile infection consistently ranked “managing or minimizing side effects” above all other domains. Despite these fluctuations, patients seldom volunteered updated values unless clinicians explicitly inquired. In the absence of a structured prompt, value shifts frequently remained unspoken, even when they held clear implications for treatment planning.

Conclusions: Values among women with mBC are dynamic, context-dependent, and often misaligned with clinical markers. Approaches that assess values only at major decision points fail to capture the ongoing, lived experience of mBC. Integrating regular, structured tools for eliciting values may help clinicians better recognize shifting priorities, facilitate more patient-centered communication, and ensure that care remains aligned with patients’ priorities.

B59

Results of a Quality Improvement Project to Enhance the Mind Workflow in an Age-Friendly Community-Based Wellness Program

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Promoting healthy aging for all requires intentional inclusion of behavioral, mental, and cognitive health as part of age-friendly care. While the Mind domain of the 4Ms approach provides a framework, guidance on implementation is limited in scope and setting. Case examples of Mind workflows in community-based programs that emphasize the role of social drivers of health (SDOH) may provide valuable insights. One such program is the VCU Mobile Health and Wellness Program (MHWP), which has provided weekly interprofessional care coordination visits with community-dwelling adults since 2012. Following the Plan-Do-Study-Act quality improvement process, we conducted a retrospective review of the Mind workflow, which follows a screen, educate, intervene approach across three domains: depression/anxiety (PHQ4, PHQ9, GAD7); substance use (TAPS 1/2);

and cognition (MiniCog). All MHWP participants with a visit between July 1, 2023 and June 30, 2025 at seven subsidized housing communities and a community health center were included. A total of 549 participants engaged in 5566 visits. Participants identified as 84% Black and 55% female with an average age of 66 years old (range 19-95). 103 visits included at least one completed Mind screener, representing 72 participants (13%). Over half of all screened visits (52%) had at least one positive result. Among the 54 positive screens, 41 (69%) received education, most often focused on mental health behaviors, chronic disease management, or SDOH. Follow-up assessment was inconsistent, including potential suicidality. Interventions were documented in half of positive-screen visits, including SDOH referrals, mental health referrals, and care coordination. Opportunities to improve the workflow were identified, along with continued PDSA cycles to expand the scope of the Mind domain, strengthen follow-up pathways, and conduct team training. These findings highlight strong screening reach and demonstrate unmet mental health, cognitive, and behavioral health needs among MHWP participants. Limitations include varied service uptake and incomplete documentation. Lessons learned may assist with more effective Mind implementation in age-friendly community-based programs.

B60 Student Presentation

Effectiveness of a Pharmacist-Led Deprescribing Intervention by Cognitive Status

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Background: Successful deprescribing requires clear communication, reinforcement, ongoing education, and goal-concordant care. It is unknown whether older adults with dementia respond as well as those with mild cognitive impairment (MCI) to a pragmatic deprescribing intervention.

Methods: Post-hoc analysis of ALIGN, a pharmacist-led deprescribing trial at 21 primary care practices in Maryland (May 2024-October 2025). Eligible patients were ≥ 65 with MCI or dementia, ≥ 5 medications, and ≥ 1 visit in the prior year. Patients and care partners received a mailed deprescribing brochure and were invited to a pharmacist-led telehealth visit. Practices were randomized to immediate vs 3-month-delayed implementation (control). Cognitive status was identified using ICD-9/10 codes and medication orders were extracted from the EHR at baseline and 3 months.

Results: Of 1640 patients contacted, 360 (22.0%) scheduled a pharmacist visit (214 intervention, 146 control). The mean age was 78 (SD 7.3); 259 (71.9%) had MCI and 101 (28.1%) had dementia, with participants taking an average of 13.8 (SD 6.6) medications. At 3 months, intention to treat analysis showed 100 (66.7%) intervention patients with MCI discontinued ≥ 1 medication vs 52 (47.7%) of controls (aRR 1.40, $p=0.05$), demonstrating a borderline but clinically meaningful effect. In the dementia group, 38 (59.4%) intervention patients and 21 (56.8%) of controls discontinued ≥ 1 medication (aRR 1.02, $p=0.96$). Discontinuation of ≥ 1 CNS potentially inappropriate medication (CNS PIM) occurred more often in the intervention groups for MCI (aRR 1.63, $p=0.25$) and dementia (aRR 2.67, $p=0.22$), though not statistically significant. No significant changes were observed in initiating new medications or total medication count.

Conclusion: Intervention effects were stronger in the MCI group, possibly reflecting greater patient autonomy and ability to follow recommendations, though limited sample size reduced power. Dementia patients were more likely to stop CNS PIM, perhaps due to perceived risk and stronger justification for deprescribing. Future studies should tailor strategies for both groups, supporting autonomy-focused approaches for MCI and risk-driven approaches for dementia.

B61 Resident Presentation

Patient and Caregiver Characteristics Associated with Caregiver Burden: Insights from the ADRD-PC Clinical Trial

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Introduction:

Caregiving for people with Alzheimer's disease and related dementias (ADRD) is associated with substantial emotional and physical burden. Interventions for ADRD caregiver burden have shown limited efficacy. This study aimed to identify patient and caregiver characteristics associated with caregiver burden among dyads enrolled in a multi-site clinical trial of dementia-specific palliative care.

Methods:

We conducted a cross-sectional analysis of baseline data from the Alzheimer's Disease and Related Dementias-Palliative Care (ADRD-PC) trial, which enrolled hospitalized patients with Global Deterioration Scale (GDS) stage 5-7 ADRD and their caregivers at five U.S. hospitals. Caregiver burden was measured using the 6-item Zarit Burden Interview (ZBI-6). Variables were obtained with structured interviews and electronic health record review. Bivariate analyses were performed using univariate linear regression and ANOVA. Variables with $p<0.1$ were included in a multivariable linear regression model to calculate adjusted associations.

Results:

Among 442 dyads, patients' mean age was 82.6 years and 56.1% had stage 6 ADRD; mean caregiver age was 58.9 years; 69.2% were women and 67.4% were White. Caregivers' mean ZBI-6 score (scale 0-24) was 7.22 (SD=5.2). In bivariate analyses ZBI-6 score was associated with patient age ($p=0.02$), race ($p=0.02$) and GDS stage ($p=0.06$), as well as caregiver gender ($p=0.01$), race ($p=0.002$), relationship to patient ($p=0.04$), self-reported health ($p<0.001$) and Family Distress in Advanced Dementia (FDAD) score ($p<0.001$). In adjusted analyses ZBI-6 scores were not associated with any patient characteristics, but higher ZBI-6 scores were associated with caregiver race (White vs. Black: 6.8 (95% CI 5.6, 7.9) vs. 5.1 (95% CI 3.8, 6.4), $p<0.01$), worse self-rated health (6.8 in excellent to 10.4 in fair health, $p<0.001$) and higher FDAD score (8.3 for upper quartile vs 5.1 for lower quartile, $p<0.001$).

Conclusion:

In a multi-site randomized clinical trial enrolling hospitalized patients with moderate to severe dementia and their caregivers, caregiver burden was higher for White vs Black caregivers, caregivers with worse self-reported health, and caregivers with higher distress which may provide guidance for future interventions.

B62

Improving Palliative Care Access Through Technology (ImPacTT): An Adaptive Nursing Home Pilot Study

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Background: Nursing homes (NHs) are common sites of death for older adults, yet many residents have unmet palliative care (PC) needs. Workforce shortages highlight the need for technology-based solutions, but PC telehealth has rarely been used proactively in NHs. The COVID-19 pandemic reshaped NH care and accelerated telehealth adoption, creating new innovation opportunities. This study reports findings from a pre-pandemic geriatric PC telehealth pilot & qualitative interviews that informed later adaptations for post-pandemic realities.

Methods: Using a quasi-experimental single-arm adaptive intervention design, we piloted the Improving Palliative Care Access Through Technology (ImPacTT) intervention in 3 NHs prior to

the pandemic to assess feasibility, acceptability & impact on symptom distress, quality of life, and advanced care planning. To inform post-pandemic adaptations, we conducted semi-structured interviews with 29 team members from 22 NHs across 9 states between June 2021-July 2022 and analyzed them thematically.

Results: Among 38 PC-eligible NH residents (mean age 83, 67% female, 52% Black), baseline symptom burden and complexity were high (avg. 14 diagnoses, 17 meds). From baseline to 3 months: depression, pain, anxiety, and tiredness decreased (77%vs59%; 62%vs35%; 16%vs7%; 48%vs35%); quality of life improved (good/excellent: 29%vs80%). Half updated POLST forms, most opting for less aggressive care. Almost 90% reported greater engagement; all found virtual PC conversations worthwhile/rewarding. Interviews revealed widespread telehealth adoption during the pandemic and strong support for its continued use. Stakeholders described creative solutions (e.g., re-purposing staff roles, technology protocols) and unanimously endorsed the ImpACTT concept, particularly its proactive PC focus, staff education, and family engagement – features largely absent before and during the pandemic.

Conclusions: Telehealth-delivered PC in NHs is acceptable, feasible and associated with improved symptoms, quality of life, and engagement. Stakeholders underscore the need for adaptive, proactive models like ImpACTT that integrate specialty geriatric PC, staff education and family engagement – features viewed as essential for sustaining telehealth innovations in post-pandemic care.

B63 Student Presentation

Unpacking Barriers to Participation in a Deprescribing Trial

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Background: For people with cognitive impairment who use high-risk medications, it is unknown whether perceived medication risk impacts willingness to participate in deprescribing interventions. We explored the discrepancy between clinically defined high-risk medication use and patient/care partner perceptions of risk during recruitment for a deprescribing trial.

Methods: We recorded reasons for declining participation in ALIGN, a pragmatic, pharmacist-led deprescribing intervention, using predefined categories and open-ended responses. Eligible patients were ≥ 65 with mild cognitive impairment (MCI) or dementia, taking ≥ 5 medications at 21 Maryland primary care clinics (May 2024 – June 2025). Categorical data were analyzed with descriptive statistics; open-ended responses were grouped into themes.

Results: Of 940 contacted, 360 (38.3%) enrolled and 580 (61.7%) declined. Participants were mainly women (61%) and white (66%), with mean age 78. Compared with participants, decliners took fewer medicines at baseline—11.2 (SD 5.55) vs. 14.0 (SD 6.59) ($p < .0001$)—and were less likely to use central nervous system potentially inappropriate medications (45.2% vs. 53.3%; $p = 0.015$). The most common reasons for declining were “not interested” ($n = 411$; 70.9%) and “not concerned about medication management” ($n = 223$; 38.5%). Both decliners and participants averaged ≥ 10 medications. Review of decliners’ open-ended responses identified four themes (Table): 1) Satisfaction with drug regimen; 2) Trust in prescribers; 3) Perceived low medication burden and safety of over-the-counter medicines; 4) Confidence in managing medicines.

Conclusions: Polypharmacy and potentially inappropriate medication use promoted engagement in a deprescribing trial, suggesting that patients perceiving greater medication risk may be more motivated to act. Decliners’ medication use still qualified as hyperpolypharmacy, indicating a gap between clinical risk and patient/care partner perceptions and a need for enhanced education on medication safety.

Theme	Decliners’ Explanations (#Medicines; #OTCs)
Satisfaction with drug regimen	“All meds have been working ok for the past four years; why change anything?” - Care partner (10; 2)
Trust in prescribers	“[I have] been with the same PCP for years. [My] PCP adjusts meds every time [we] meet.” - Patient (11; 1)
Perceived low medication burden and safety of over-the-counter medicines	“Not taking a lot of medications – more vitamins than prescribed meds” - Patient (8; 5)
Confidence in managing medicines	“[We are] on top of things regarding med management [...] and are in close contact with the doctor” - Care partner (18; 5)

B64

Advancing Patient Age Does Not Lessen the Benefits of Carotid Artery Stenting in Asymptomatic Patients with $\geq 70\%$ Stenosis

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Background: A rationale for carotid stenting (CAS) vs. carotid endarterectomy (CEA) was that a less invasive procedure would have lower risk leading to relative advantages for geriatric patients. Unexpectedly, randomized trials in the U.S. and Europe showed greater procedure-related stroke risk following CAS compared to CEA in patients age ≥ 70 years. Age-related risk was not detected for CEA.

Methods: The Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial (CREST-2) randomized 2485 asymptomatic patients with $\geq 70\%$ stenosis at 155 centers in 5 countries into 2 randomized trials, CAS vs. Medicine or CEA vs. Medicine. The primary endpoint was any stroke or death within 44 days plus ipsilateral stroke thereafter up to 4 years. Effect modification was tested with age dichotomized $< \text{or} \geq 70$ years.

Results: For the CAS trial, revascularization compared to medicine showed an absolute benefit of 2.8% for those < 70 and an absolute benefit of 3.7% for those ≥ 70 in stroke prevention (Table). For the CEA trial, revascularization showed an absolute benefit of 1.8% for those < 70 and an absolute benefit of 1.3% for those ≥ 70 in stroke prevention. None of these differences were significant. However, the results for patients of all ages combined showed a significant benefit for CAS but not for CEA in stroke prevention.

Conclusions: The CREST-2 trial showed a stroke-prevention benefit for CAS but not for CEA compared to medical treatment alone. An age effect for CAS or CEA was not found, and a relative advantage for CEA compared to CAS reported in the prior decade was not observed. Stenting should be considered for patients ≥ 70 with high-grade asymptomatic carotid stenosis if they are good procedural candidates.

Absolute difference in the primary endpoint at 4 years in the CAS trial

Age	< 70		≥ 70	
	Diff.	95% CI	Diff.	95% CI
Medicine Alone	5.1	2.5 – 7.9	7.0	3.7 – 10.8
CAS + Medicine	2.3	0.7 – 4.3	3.3	1.3 – 5.7
Difference	2.8	-0.4 – 6.0	3.7	-0.3 – 8.0
Difference in Diff.	-0.9 (-6.3 – 4.4)			

B65

Clinical Correlates of Vertebral Fractures in Long-Term Care

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Background:

Older adults in long-term care (LTC) have a high burden of vertebral fractures (VFs), but it is uncertain which clinical characteristics are most strongly associated with VFs beyond bone measures.

Methods:

In the Preventing Osteoporosis Using Denosumab (PROUD) trial (201 men and women, mean age $\approx$ 81 years), prevalent VFs were defined by vertebral fracture assessment (VFA, Genant grade 2–3). We performed logistic regression analyses of VFs with bone (BMD), muscle (ALM/ht², gait speed, chair-stand), and clinical variables (frailty, comorbidity index, ADLs, IADLs, ambulatory status, falls, bone turnover markers) across three models: (A) Bone, (B) Bone + Muscle, and (C) Full Clinical.

Results:

Forty-five percent of participants had a VF at baseline. Frailty status was the only significant correlate (OR $\approx$ 2.7, 95% CI 1.5–5.0). Neither BMD nor muscle indices were significant after adjustment. Functional dependence (ADLs, IADLs, ambulatory status) and comorbidity index also showed no independent association.

Conclusion:

In LTC, vertebral fractures were common, but frailty was the only consistent correlate. Traditional skeletal markers such as BMD may be less informative in this setting, likely because degenerative spine disease inflates BMD values and masks true bone fragility. While these findings are based on imaging markers rather than clinical VFs, they argue for a shift in fracture risk assessment toward a focus on frailty and functional vulnerability in this population.

B66

Patients with Anxiety and Depression Symptoms Can Engage in Advance Care Planning and Preferences Change in Response to the PREPARE ACP Program

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Background Advance care planning (ACP) helps patients identify their values and goals for medical care. Depression and anxiety, affecting up to 20% of older adults, may influence whether patients engage in ACP and decide what matters most. Little is known about mental health and ACP; therefore, we determined whether depression and anxiety symptoms affect ACP engagement and preferences in response to an evidence-based intervention (PREPAREforYourCare.org). **Methods** This is a subgroup analysis of the PREPARE RCT. Participants, from a safety-net, urban hospital, were aged $\geq$ 55 years, and spoke English or Spanish. Participants received the PREPARE program plus an easy-to-read advance directive (AD) or the AD alone. Depression and anxiety symptoms were self-reported using the PHQ-8 and GAD-7, with scores $\geq$ 5 indicating at least mild symptoms. Outcomes included new ACP documentation, the validated ACP Engagement Survey (5-point Likert scale), and a question about not valuing life extension concerning future care (“some health situations may make life not worth living”). Chi-square, t-tests, and logistic regression were used, adjusting for health literacy and prior ACP documentation. **Results** The mean age of 986 participants was 63 years, 61% were women, 45% were Spanish-speaking, 27% had prior ACP, 39% had limited health literacy, and 46% had at least mild depression or anxiety symptoms. At baseline, participants with depression/anxiety symptoms had higher odds of not valuing life extension vs. those without symptoms: 1.40 (95% CI 1.04–1.88, $p=0.02$). At 12 months, there were no differences in new ACP documentation (38% depression/anxiety vs 37% without, $p=0.62$) or mean ACP Engagement scores (3.24 $\pm$ 0.98 depression/anxiety vs 3.28 $\pm$ 1.03 without, $p=0.58$). There were also no differences in the odds of not valuing life extension: 1.04 (95% CI 0.75–1.45, $p=0.80$). **Conclusion** Participants with depression and anxiety symptoms were equally likely to engage in ACP documentation and discussions. Clinical implications include that patients with depression and anxiety can engage meaningfully in ACP, that symptoms may be associated with expressed values, and that preferences should be revisited over time.

B67

Impaired contrast sensitivity and stereoacuity increases risk of a second fall in older adults

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Background: To determine the relationship between visual impairment and risk of a second fall in older adults.

Methods: Older adults ($n=1859$) from the Health, Aging and Body Composition Study who underwent visual function testing (visual acuity (VA), log contrast sensitivity (LCS), Frisby stereoacuity (SA)) in year 3 and who experienced a fall were investigated for risk of a second fall over a 5-year follow-up period using Kaplan-Meier curves and Cox proportional hazards models with interval-censoring. Visual impairment (VI) was defined by VA<20/40, LCS<1.55 or SA>85.

Results: Mean age was 75 (range 73–78) years, with 55.7% female and 36.2% black race. VI was associated with a higher risk of a second fall in Kaplan-Meier curves (log-rank $p=0.039$) and the unadjusted Cox proportional hazards model (HR 1.16 (1.01, 1.33), $p=0.04$) but not the adjusted model ($p=0.08$). VA<20/40 was not significantly associated with second fall risk ($p>0.10$). Both LCS<1.55 and SA>85 were associated with a higher risk of falls on Kaplan-Meier curves (log-rank $p=0.002$ and $p=0.003$) as well as both unadjusted and adjusted Cox models (adjusted HR 1.26 (1.08, 1.47), $p=0.003$ and 1.25 (1.09, 1.46), $p=0.002$, respectively).

Conclusions: Older adults with moderately impaired vision, especially in contrast sensitivity and stereoacuity, were at higher risk of experiencing a second fall over a 5 year follow-up period. Future studies should develop interventions to address visual impairment in older adults who have had one fall in order to prevent second falls.

Associations of composite visual impairment (and separately, its component variables) with time to second fall, among Health-ABC study participants with a first fall (index time).

Vision Variables	Unadjusted Hazard Ratio (95% Confidence Interval); p-value	Adjusted Hazard Ratio (95% Confidence Interval); p-value
Visual Impairment	1.16 (1.01, 1.33); 0.0400	1.13 (0.98, 1.30); 0.0843
Visual acuity <20/40	1.11 (0.97, 1.27); 0.1422	1.08 (0.93, 1.24); 0.3204
Log contrast sensitivity <1.55	1.27 (1.11, 1.45); 0.0006	1.26 (1.08, 1.47); 0.0050
Frisby stereoacuity >85	1.25 (1.08, 1.45); 0.0030	1.26 (1.09, 1.46); 0.0020

Adjusted model includes adjustment for age, sex, and race (Black or other). Second fall is interval-censored within year of occurrence. Hazard ratio (95% confidence interval); p-value displayed for all table cells.

B68

Identifying Factors Associated with Prolonged Hospitalizations for Community-Dwelling Adults with Dementia

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Background: People living with dementia (PLWD) are more likely to be hospitalized and have longer hospital stays compared with the general population. Prolonged hospitalizations are associated with inpatient complications, functional decline, and mortality. This study aimed to identify patient-level factors associated with prolonged admissions for PLWD.

Methods: Secondary analysis of a stepped-wedge, cluster randomized trial that enrolled community-dwelling adults hospitalized at eight Veterans Affairs medical facilities between August 2017 and August 2019. A logistic regression model was used to identify patient-level factors associated with prolonged hospitalizations for PLWD.

Results: 14679 individuals were included in this cohort – 2612 of whom had a diagnosis of dementia. PLWD had an average length of stay of 8.7 days (SD 9.1), compared with 6.5 (SD 4.7) for those without dementia. 138 (5.3%) of those with dementia were admitted to the hospital for at least 21 days. Among PLWD, social vulnerability (OR 1.74, 95% CI 1.16, 2.61), higher disease burden (OR 1.06, 95% CI 1.01, 1.10), and presence of delirium at admission (OR 1.55, 95% CI 1.07, 2.26) were associated with higher odds of prolonged admission. In contrast, greater clinical frailty was associated with lower odds of prolonged stay ($p=0.006$).

Conclusion: Several patient-level factors available at time of admission are associated with prolonged hospitalizations for PLWD. These findings can help identify vulnerable PLWD at risk of prolonged hospitalization, and guide clinician conversations regarding their complex discharge needs at time of presentation. Further research is needed to explore the reason for these relationships, particularly frailty.

B69 Encore Presentation

Sustained excess cognitive decline after surgery in an epidemiological cohort of older adults

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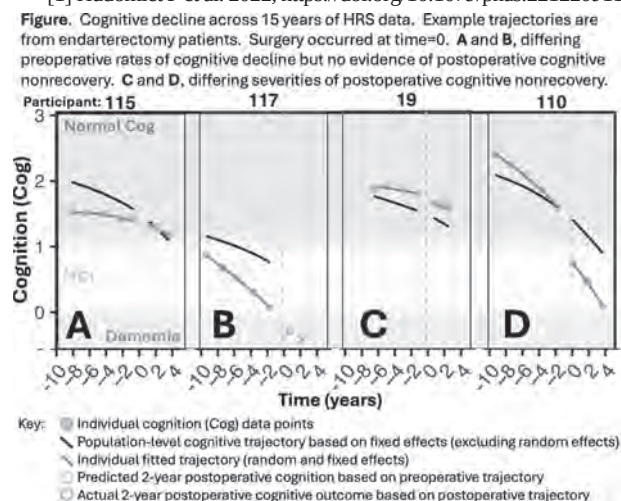
Background: Patients with sustained (>2 year) excess cognitive decline after surgery have not been systematically studied. We identified persistent postoperative decline greater than expected in a representative cohort of older Americans.

Methods: In HRS-Medicare data, 7,424 participants aged 65+ underwent 1 of 10 prespecified types of major noncardiac surgeries. We modeled Cog (derived from cognitive tests, proxy reports, and HRS covariates[1]) using linear mixed effects models with discontinuity at time of surgery. Two authors adjudicated $n=500$ random surgeries to identify sustained postoperative decline unexplained by pre-surgery cognitive trajectory, with a 3rd author resolving disagreements.

Results: Of 500 encounters, 106 had insufficient Cog data. Of 394 remaining, 31 (7.9%) had sustained excess decline in Cog after surgery. Preoperative rate of decline was heterogeneous (**Figure, A + B**), and excess postoperative decline ranged from mild to severe (**Figure, C + D**). Cognitive recovery occurred across the cognitive spectrum (**Figure, A + B**); the 10 participants with dementia all recovered cognition. For $n=71$ with baseline MCI, 15% did not recover, 2.7-fold higher odds of excess decline (95% CI 1.2–5.9, $p=0.014$). Median excess decline was 0.29 Cog units [IQR 0.16–0.48] 2 years after surgery, compared with expected 2-year Cog.

Conclusion: Although most older adults across the spectrum of baseline cognition cognitively recover, we identified sustained (>2y) excess cognitive decline after surgery in 8%.

[1] Hudomiet P et al. 2022, <https://doi.org/10.1073/pnas.2212205119>



B70

Incretin Therapies in Older Adults: Gaps in the Evidence

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Background

Nearly 40% of adults ≥ 60 years of age have obesity. Incretin mimetics, including glucagon-like peptide-1 receptor agonists (GLP-1RAs), dual and triple agonists, cause significant, rapid weight loss. About 21% of adults ≥ 65 with diabetes and 8% without diabetes reported using incretin therapies in 2024. Muscle mass and function may decline with age, and the safety and impact of incretins on muscle mass and function among older adults are not clearly established. Data on the use of incretin therapies among older adults are critically needed to guide incretin therapy use for a growing array of conditions in older adults.

Methods

We narratively reviewed major published clinical trials of incretin therapies for weight management and/or cardiometabolic conditions in adults with overweight or obesity from 2009-present. We extracted data on inclusion of adults ≥ 60 years, body composition, muscle strength or physical function, frailty, and falls.

Results

We reviewed 55 randomized, controlled trials that examined the impact of incretin therapies among adults with overweight and/or obesity (26), type 1 diabetes (4), type 2 diabetes (23), sleep apnea (1), and heart failure (1). The mean age of participants across studies was 50.6 years (mean age range: 34–63.7 years). Few studies reported body composition (7), physical function (1), grip strength (1), frailty (1), or falls (0). Five studies included some form of lifestyle counseling, and seven recommended adherence to standard physical activity recommendations of 150 minutes/week.

Conclusions

Evidence on side effects of incretin therapies that are of specific concern to older adults (e.g., physical function, muscle loss, frailty, and falls) is limited. Counseling on lifestyle modification, which may help prevent some adverse effects of incretin therapies, are not consistently included in clinical trials. Future studies should ensure inclusion of older adults and collect data on frailty, muscle mass and quality, and physical function to fill these critical gaps.

B71

Trends in Overactive Bladder and Urinary Incontinence Diagnoses Among U.S. Nursing Home Residents

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Background: Urinary incontinence (UI), including overactive bladder (OAB), is common in nursing homes (NH) and associated with diminished quality of life, increased risk of injurious falls, and accelerated functional decline. There is limited epidemiologic evidence on changes in UI/OAB diagnoses and symptoms over time in this population.

Methods: We conducted a serial cross-sectional study using NH electronic health record (EHR) data between January 1, 2015, to March 31, 2024, supplied by PointClickCare, the leading EHR

provider for long-term and post-acute care. For each quarter, we identified residents' first Minimum Dataset (MDS) clinical assessment (index date). At the index date, we identified active UI/OAB diagnoses and UI symptoms recorded in the MDS. We calculated descriptive prevalences of UI/OAB diagnoses in every quarter to assess changes over time, and stratified by covariates of interest (e.g. Alzheimer's disease and related dementias, gender, medications).

Results: We identified 174,096 and 986,567 NH residents in the first (Q1) and final (Q37) quarters, respectively. The prevalence of any UI-related diagnoses increased over time, from 6.23% to 8.25%. OAB diagnoses increased more than any other UI-related diagnosis from 1.91% to 4.10%. UI symptoms, as documented in the MDS, were substantially more frequent than UI-related diagnoses captured in the EHR and increased from 66.9% to 74.9% over the study period.

Conclusion: UI diagnoses, including OAB, among NH residents have increased modestly over the past decade, yet there was a large gap between the documentation of MDS UI symptoms and EHR UI diagnoses. This finding has methodological implications for defining epidemiologic cohorts of residents with UI/OAB, and prompts future research into what explains the discrepancies in documentation.

Table 1. UI/OAB Diagnoses and UI Symptoms

	Q1 (N=174,095)	Q37 (N=986,554)
Any urinary incontinence related diagnosis*	10854 (6.23)	81422 (8.25)
Urinary incontinence, unspecified (788.3, R32)	3684 (2.12)	21293 (2.16)
Overactive bladder (N32.81, 596.51)	3326 (1.91)	40494 (4.11)
MDS-recorded incontinence (H0300=1, 2, or 3)	116,364 (66.8)	738,778 (74.9)

* Includes OAB, UI unspecified, urge incontinence, urgency of urination, urinary frequency, functional UI, mixed incontinence, urgency of urination, nocturia, and continuous leakage

B72 Resident Presentation

Coronary Calcification Score Predicts Twenty-Year Mortality in Older Japanese-American Men: The Kuakini Honolulu Heart Program

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Background: Coronary artery calcium (CAC) reflects the presence of coronary atherosclerosis and is widely validated as a predictor of cardiovascular disease (CVD) morbidity and mortality, even after accounting for CVD risk factors in young and middle-aged adults. However, few studies have examined this association in adults over the age of 85, particularly among Asian-ancestry populations. We examined the association between CAC and 20-year all-cause mortality in a population of older Japanese-American men.

Methods: The Kuakini Honolulu Heart Program is a longitudinal population-based cohort study of 8,006 Japanese-American men between the ages of 45 and 68 years, followed since 1965. In the ninth exam cycle (2004–05), 224 participants with good cognitive function, aged 84 to 95 years (mean=86), underwent multislice CT scanning to measure CAC using a standardized protocol. All-cause mortality data were available for 20 years, through December 2024. Co-variables included age, baseline CVD risk factors and prevalent chronic diseases (CHD, stroke, cancer, emphysema). CAC scores were organized into 5 groups (0, 1–99, 100–399, 400–999, ≥1,000) and also into quartiles for analysis.

Results: At the time of assessment, 3.6% of men had CAC=0 and 31.7% had CAC ≥1,000. Age-adjusted death rates increased across CAC groups from 76.9 (CAC=0) to 141.9 (CAC≥1,000) per 1,000 person-years follow-up, p for trend=0.02; a similar dose-response relationship was observed across CAC quartiles (108.8 to 147.5; p for trend=0.001). In multivariate Cox regression models with lowest CAC as the reference group, those in the 2 highest CAC groups had over two-fold higher mortality (CAC=400–999: RR=2.28, 95% CI=1.04–5.01, p=0.04; CAC≥1,000: RR=2.42, 95% CI=1.09–5.35; p=0.03). Similar dose-response associations were seen for CAC quartiles.

Conclusions: We found that higher CAC was a strong, independent risk factor for 20-year all-cause mortality in older Japanese-American men. A single CAC assessment after the age of 80 offers meaningful insight into future mortality risk and may aid late-life risk stratification and patient counseling.

B73

Where Do People With Dementia Die? 25-Year National Trends and Factors Associated With Place of Death

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Introduction

The number of dementia-associated deaths has increased substantially in the United States in recent years. The place of death is a key indicator of the quality of end-of-life care for individuals with dementia since the location impacts the type and intensity of medical interventions and the alignment with patient preferences for comfort-focused care. However, recent national-level studies describing trends in the place of death among dementia decedents remain scarce.

Method

We analyzed U.S. mortality data from 1999 to 2023 using the CDC Wide-ranging Online Data for Epidemiologic Research. Dementia-associated deaths were identified using ICD-10 codes F01, F03, and G30. Trends in crude rates, age-adjusted mortality rates, and place-of-death distribution were examined. Multivariable logistic regression identified demographic predictors of home deaths, adjusting for age, sex, race, ethnicity, and education.

Results

During this period, crude dementia-associated mortality increased from 26.2 to 66.7 per 100,000, and age-adjusted rates rose from 27.1 to 54.4 per 100,000. Home deaths increased from 11.6% in 1999 to 26.9% in 2023 (p<0.001), hospital deaths declined from 14.9% to 8.2% (p<0.001), and nursing home deaths decreased from 67.8% to 49.2% (p<0.001). During the COVID-19 pandemic, nursing home deaths fell from 54.2% in 2019 to 46.6% in 2021, while home deaths rose from 22.8% to 30.0%. Home death occurred more often among people of color than among White individuals (odds ratio [OR] 1.79, 95% confidence interval [CI] 1.76–1.82), among Hispanic than non-Hispanic individuals (OR 2.41, 95% CI 2.36–2.46), and among those with a college education or higher compared with those with a high-school education or less (OR 1.03, 95% CI 1.02–1.04).

Conclusion

Over the past 25 years, dementia decedents in the U.S. have become increasingly likely to die at home and less likely to die in hospitals or nursing facilities. As home becomes a more common place of death, strengthening caregiver support and home-based services will be essential.

B74 Student Presentation

Partnered Sexual Activity & Sexual Problems in Older Adults with Late-Life Functional Impairments: Findings From a Nationally-Representative Survey

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Background: Sexual health is vital to well-being across the lifespan but remains under-discussed in clinical care for older adults with functional limitations, who may be assumed to not engage in partnered sexual activity. The current study examines the relationship between sexual health and functional limitation among community-dwelling older adults.

Methods: We analyzed responses from the National Social Life, Health & Aging Project (NSHAP) – a nationally representative study of community-dwelling older adults ≥ 60 years of age in the US. Functional impairment was defined as any difficulty performing activities of daily living (ADLs). We focused on participants' reports of any partnered sexual activity (yes/no) and experience with sexual problems in the past 12 months stratified by gender: lack of interest in sex, climaxing too quickly, inability to climax, pain during intercourse, sex not being pleasurable, anxiety about performance, difficulty with lubrication (women), and erectile dysfunction (men). Survey-weighted multivariable regressions were used to calculate age-adjusted predicted probabilities of partnered sexual activity and sexual problems for those who were functionally impaired and those who were not.

Results: 3071 participants were identified (mean age: 70 years; 53% female; 17% non-White), 812 (26%) of which were functionally limited. For both men and women, functional impairment was associated with a lower probability ($p < 0.05$ for all significant comparisons) of any partnered sexual activity (48% vs 63% for men; 34% vs 45% for women). The effect of functional impairment on sexual activity did not significantly differ between genders. Functional impairment was associated with higher probabilities of 4 sexual problems in men: lack of interest in sex (41% vs 30%), an inability to climax (35% vs 22%), sex not being pleasurable (11% vs 5%), and erectile dysfunction (59% vs 36%); and higher probabilities of 2 sexual problems in women: lack of interest in sex (65% vs 54%) and an inability to climax (34% vs 23%).

Conclusion: In a nationally representative survey of US older adults, nearly half of men and one-third of women with functional limitations engaged in partnered sexual activity. Clinicians should be attuned to the specific risks for sexual health problems among older adults with functional limitations.

B75

Longitudinal Association Between Vision Impairment and Frailty: Evidence from the National Healthy Aging Trends Study. N. Kumar,¹ M. Kabeto,¹ A. Galecki,^{1,2} J. R. Ehrlich.^{3,4} 1. *Geriatrics and Palliative Care, University of Michigan Michigan Medicine, Ann Arbor, MI*; 2. *Department of Biostatistics, University of Michigan, Ann Arbor, MI*; 3. *Department of Ophthalmology and Visual Sciences, University of Michigan, Ann Arbor, MI*; 4. *Survey Research Center, Institute for Social Research, University of Michigan, Ann Arbor, MI*.

Background: Frailty is an emerging public health issue in aging populations. It is associated with an increased risk of falls, disability, admission to long-term care and mortality. Vision impairment, a highly prevalent condition in aging populations, is linked to several adverse outcomes, including an elevated risk of frailty. However, the longitudinal relationship between frailty and vision impairment, especially when assessed using objective measures of visual function like visual acuity and contrast sensitivity, has not been well established.

Methods: We used data from Rounds 11-14 (2021-24) of National Healthy Aging Trends Study, a nationally representative cohort study of Medicare beneficiaries aged ≥ 65 years. Distance visual acuity, near visual acuity, and contrast sensitivity (CS) were measured using tablet-based tests at each visit. Distance and near vision impairments (DVI and NVI) were defined as distance and near visual acuity worse than 20/40 respectively. Contrast sensitivity impairment (CSI) was defined as log CS < 1.55 . Frailty was defined as presence of ≥ 3 of the following criteria: unintentional weight loss of > 10 pounds, weakness, exhaustion, low physical activity, and slowness. Longitudinal associations between vision impairment and frailty were analyzed using survey logistic regression models accounting for complex survey design and repeated measures.

Result: The study sample consisted of 2546 community-dwelling older adults with a mean age of 80.9 years (SD:6.0) and 56.5% were female. Participants were followed for a median duration of 34.5 months (IQR: 21.3-35.5). At baseline, 12.0% had DVI, 24.5% had

NVI and 23.5% had CSI. Older adults with vision impairment had significantly higher odds of frailty compared to those without. DVI OR (95%CI): 1.40 (1.07, 1.83); NVI OR (95%CI): 1.43 (1.15, 1.78); CSI OR (95%CI): 1.63 (1.31, 2.03).

Conclusion: Vision impairment is longitudinally associated with greater frailty risk in older adults.

B76

Neighborhood problems and prescribed opioid use among older Brazilian adults: a population-based study

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Background

Opioid analgesics are frequently used by older adults, leading to falls, cognitive impairment, and serious adverse drug events. Neighborhood problems may affect pain management (e.g., increasing stress, constraining access to non-pharmacologic treatments). However, these contextual drivers remain poorly characterized. We investigated the association between the number of neighborhood problems and prescribed opioid analgesic use in older Brazilian adults, independent of income and other factors.

Methods

We analyzed cross-sectional, survey-weighted data from urban-dwelling adults aged ≥ 50 years in ELSI-Brazil (a nationally representative study comparable to the HRS). The primary predictor was the number of neighborhood problems, defined by 9 self-reported items (yes/no): abandoned buildings, trash accumulation, heavy traffic noise, pests, unsafe sidewalks, poor street lighting, limited police presence, perceived crime/violence, and theft/burglary. For descriptive analyses, the number of neighborhood problems was categorized into quartiles. The primary outcome was self-reported use of prescribed opioid analgesics in the past 3 months. We fit regression models to estimate adjusted prevalence ratios (aPRs). Covariates included age, sex, private health plan, number of chronic conditions, outpatient/doctor visits, and household income.

Results

We included 8,281 respondents representing 45.4 million people (54% female; 95%CI=52–57%). Mean age was 63.3 years (95%CI=62.6–64.1), with a median of 2 chronic conditions (IQR, 1–3) and 2 neighborhood problems (IQR, 0–4). The prevalence of prescribed opioid analgesic use was 11% (95%CI=9–13%). In unadjusted analyses, prevalence was 17% (95%CI=14–17%) among participants who reported ≥ 5 neighborhood problems (highest quartile) vs. 7% (95%CI=5–9%) among those who reported ≤ 1 problem (lowest quartile; $p < 0.001$). In adjusted analyses, each additional neighborhood problem was associated with a 6% higher prevalence of prescribed opioid analgesic use (aPR=1.06, 95%CI=1.01–1.12; $p=0.015$).

Conclusions

Among older Brazilian adults, a higher number of self-reported neighborhood problems was independently associated with greater use of prescribed opioid analgesics after accounting for household income, health status, insurance coverage, and healthcare utilization.

B77 Student Presentation

Challenges and Opportunities to Improve Hospice Care for People Living with Dementia: A Qualitative Study of Family Caregivers, Nurses, and Prescribing Clinicians

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Background: Dementia is now the most common hospice diagnosis, yet eligibility criteria and care models were developed around cancer and often misaligned with dementia's prolonged, unpredictable course. Understanding the perspectives of family caregivers, hospice

nurses, and prescribing clinicians is essential to designed dementia-informed hospice care.

Methods: We conducted semi-structured interviews with family caregivers (N=20), hospice nurses (N=19), and hospice prescribing clinicians (N=23) across diverse U.S. regions and hospice settings. Interviews explored challenges and opportunities for improving dementia hospice care. Audio-recordings were transcribed and analyzed using thematic analysis, with comparison across groups to identify convergent and divergent perspectives.

Results: Participants described three overarching challenge domains. **(1) Prognostic uncertainty:** Difficulty predicting decline delayed hospice enrollment, complicated eligibility determinations, and created recertification challenges, particularly when patients temporarily stabilized with supportive care. **(2) Patient-related challenges:** Communication loss, behavioral symptoms, and absence of decisional capacity created clinical uncertainty for nurses and ethical complexity for prescribers, while caregivers struggled to interpret symptoms and uphold preferences. **(3) Caregiver burden:** Families described years of 24/7 supervision, exhaustion, anticipatory grief, and helplessness watching prolonged decline. Across groups, respondents endorsed improvements aligned with a dementia-informed hospice model, including earlier access through less restrictive eligibility criteria, expanded in-home aide and respite support, and enhanced caregiver education and anticipatory guidance, with caregivers uniquely emphasizing the need for clearer, dementia-specific preparation.

Conclusions: Dementia hospice care requires a model that anticipates communication loss, behavioral symptoms, prolonged decline, and sustained caregiver strain. Policy adaptations to allow earlier enrollment, greater in-home support, structured caregiver education, and dementia-specific staff training may improve patient comfort, caregiver well-being, and provider satisfaction while better aligning hospice care with the realities of advanced dementia.

B78 Student Presentation

“Did You Read My Story?”: The Impact of My Life, My Story in the Electronic Health Record on Subsequent Patient-Provider Interactions

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Background: As the U.S. population ages, integrating patients' values and life experiences into care is increasingly important. The My Life, My Story (MLMS) initiative places patient narratives into the electronic health record (EHR) to humanize care, yet little is known about how story inclusion affects later clinical interactions.

Methods: We conducted a qualitative study using semi-structured telephone interviews with adults ≥65 years who completed an MLMS narrative within an academic health system (from 2023-2024). Of 48 eligible individuals, 10 completed interviews (25-51 minutes). Transcripts were de-identified and coded using a combined deductive-inductive approach to identify themes regarding the influence of MLMS on communication, care experiences, and personal meaning.

Results: Three themes emerged. (1) Impact on clinical interactions: Participants whose clinicians referenced their story felt more fully known and described greater trust, validation, and connection. When stories were never mentioned, participants perceived little benefit. (2) Perceived value for others: Many believed MLMS could help providers better understand patients or support others with similar conditions, reflecting older adults' desire to contribute to and support future generations. (3) Personal significance: Sharing the story prompted reflection on values, life events, and priorities, sometimes motivating discussions about future wishes or advance care planning.

Conclusions: MLMS can enhance patient-centered care, but its effect depends on clinician engagement with the narrative. When

acknowledged, stories deepen communication and foster recognition of patients as whole persons. Integrating narrative review into routine chart preparation, team communication, and clinician training may strengthen the initiative's impact. MLMS represents a scalable narrative medicine approach that can promote empathy, continuity, and humanization of care for older adults.

B79

Characterizing Communication and Decision-Making Processes Among Patients and Providers in Cognitive Workups in Primary Care Clinics

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Background:

A number of challenges to timely dementia diagnosis in non-specialist (i.e. primary care and geriatrics) settings have been identified, including reluctance to discuss symptoms, insufficient time, and lack of expertise among providers. New Alzheimer's disease (AD) blood tests may improve diagnostic speed and accuracy. However, little evidence exists about barriers to effective decision-making around diagnostic workups, or how shared decision-making can be fostered.

Methods:

We audio-recorded 30 first-time consultations about memory impairments in geriatrics and primary care clinics, and analyzed them using inductive qualitative content analysis. Analysis focused on the domains in which care was provided and described processes of communication and decision-making. Our inter-disciplinary team first descriptively coded transcripts, then developed categories through axial coding in consensus-based discussion.

Results:

We identified three overarching care needs in consultations: informational needs; emotional needs; and practical needs. These domains were addressed by providers through a number of communicative strategies including: reframing; assessment; advice, building trust and rapport, and reassurance. Decisions focused on therapeutic and diagnostic options. Though multiple decisions were made during the course of a visit, most decisions were made by the provider through tacit assent by the patient and any support persons present. Typically only a single decision was made through more extensive discussion or deliberation.

Conclusions:

Clinicians try to address care needs by aligning with patients and support persons in three main areas, and decisions were typically made with limited discussions. These findings identify areas in which communication tools could facilitate and support shared decision-making during diagnostic workups. Understanding these processes will be essential to supporting clinicians and patients in making decisions about novel AD blood tests that are in line with patient preferences.

B80 Student Presentation

A POLST on a T-Shirt? Clinician Comfort with Unconventional DNR Orders

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Background

Physician Orders for Life-Sustaining Treatment (POLST) forms convey emergency care preferences to support goal-concordant care, but documentation is not always available at the point of care. Patients have expressed their preferences for care via unconventional Do Not Resuscitate (DNR) orders such as tattoos and bracelets. Prompted by an older adult who presented to primary care clinic with a screen-printed T-shirt of his POLST indicating “DNR, Comfort Measures Only”, we surveyed clinicians regarding their perspectives on honoring unconventional DNR orders.

Methods

In November 2025, we conducted an anonymous, voluntary, electronic Qualtrics survey by convenience sampling via email and text messages. Training background and prior training in cardiopulmonary resuscitation (CPR) were collected. Respondents reviewed three vignettes of an older adult found unresponsive with: (1) a T-shirt with a screenprinted copy of their POLST indicating DNR, (2) a chest tattoo reading “DO NOT RESUSITATE”, and (3) a retail DNR bracelet. For each, respondents were asked if they would initiate CPR (Yes/No), and rated comfort with their decision on a Likert Scale (1=Very Uncomfortable - 5=Very Comfortable). An open-ended question invited comments.

Results

Thirty of 35 clinicians responded (86%); most were 25 attending physicians 25/30, with others including advanced practice providers, geriatric medicine fellows, and a nurse. All participants had received training in CPR. For the T-shirt POLST vignette, 17/30 would not initiate CPR; 20/30 felt uncomfortable or very uncomfortable with their decision. For the tattoo vignette, 10/30 would not initiate CPR; 16/30 felt uncomfortable or very uncomfortable with their decision. For the bracelet vignette, 24/30 would not initiate CPR; 17/30 felt uncomfortable or very uncomfortable. Free text responses discussed concerns of legality and credibility of the atypical orders and tension with respecting the patient’s stated wishes.

Conclusions

Clinicians were most likely to honor a DNR bracelet, less likely to honor a POLST on a T-shirt, and least likely to honor a DNR tattoo. Across all scenarios, most felt uncomfortable with their decision. A small, convenience sample, and primarily physician respondents limit generalizability. Given the variability in clinician responses and discomfort, standardization of portable DNR orders are needed to ensure patients receive goal concordant care when formal documentation is unavailable.

B81

Ethical Considerations in the Development of a Decision Support Tool for Alzheimer’s Disease Blood Biomarker Testing

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Background:

Primary care providers (PCPs) can use Blood Biomarker (BBM) tests for Alzheimer’s disease (AD) to quickly and accurately diagnose patients with cognitive complaints. However, little is known how PCPs view ethical aspects of testing and how these can be addressed through decision support.

Methods:

We conducted focus group sessions with PCPs utilizing user-centered design methodology. PCPs were recruited through convenience sampling. Over the course of 5 sessions we co-designed a pathway tool to support clinical and shared decision-making and results communication about BBM testing in primary care. Materials were iteratively refined based on participant feedback. We transcribed and qualitatively analyzed sessions using the RITA (rapid identification of themes from audio recordings) method.

Results:

12 PCPs (10 females and 2 males) from Family Medicine (n=4), Internal Medicine (n=7) and Geriatrics (n=1) participated, who were mostly white (n=11). PCPs identified several ethical issues that they wanted a BBM tool to address, including: 1) Fostering shared decision-making with the patient-caregiver dyad about testing by balancing patient autonomy with their support person’s input. 2) Clarifying the risks versus benefits of testing, particularly if patient and support

person’s goals are not aligned. 3) Maintaining confidentiality by ensuring that patients control who can access results, and counseling about medico-legal implications including driving restrictions or activation of healthcare power of attorney. 4) Minimizing potential anxiety from sharing results with patients and support persons through clear communication materials. Each of these ethical considerations was addressed by incorporating guidance for PCPs into the tool.

Conclusion:

PCPs highlighted several ethical considerations that a BBM pathway should address, from initial workup through the disclosure of test results. The ethical and patient-centered use of BBMs in primary care may be strengthened through promoting shared decision-making processes, assuring transparent communication about confidentiality and testing implications, and providing guidance for emotionally sensitive test result disclosures to minimize psychological harm.

B82

Experiences with medication management among older adults living alone with cognitive impairment

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BACKGROUND: Over one-fourth of older Americans with cognitive impairment (CI) live alone. Many lack support for medication management and face a high risk of medication-related harm. We aimed to elucidate the experiences with medication management of older adults living alone with CI and their social contacts (family members or other familiar persons).

METHODS: This qualitative study was conducted May 2016 - February 2024 in California, Louisiana, and Michigan and involved adults ≥ 55 years with CI from diverse racial/ethnic backgrounds and social contacts. We interviewed participants in English, Spanish, Cantonese, or Mandarin on average 4 times (486 interviews total), mostly in their homes. We used combined inductive/deductive thematic analysis to analyze interviews.

RESULTS: We interviewed a total of 116 older adults living alone with CI (86 [74.1%] women; median age, 74.0 years [range, 57-103]) and 54 social contacts (44 [81.5%] women; median age, 58.6 years [range, 29-89 years]). We identified 4 themes regarding medication management: (1) Cognitive barriers and unreliable information; (2) Resistance to medications; (3) Limited therapeutic alliance with professionals; and (4) Navigating logistical difficulties associated with medication management. Within themes, living alone status conferred specific challenges: lacking external medication reminders, fearing side effects (particularly drowsiness) when alone, withholding information from clinicians to maintain independence, and encountering logistical difficulties without advocates. Participants received crucial but spotty support with medication management from non-cohabiting social contacts; nevertheless, both groups conveyed a sense of precarity related to medication management.

CONCLUSIONS: This qualitative study encompassing diverse participants from 3 states highlights the significant challenges older adults living alone with CI experience in managing their medications, including lacking reminders, fearing side effects, and navigating health system difficulties without advocates. Identification of overlapping CI and living-alone status should spur targeted efforts to overcome medication-related challenges in this population. In addition, more home- and community-based services are needed to support individuals living alone with CI with medication management.

B83

Journeying Beyond Caregiving: Identity Reconstruction After the Loss of a Care Recipient

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Background: Family caregivers play a critical role in supporting older adults with complex medical and emotional needs. While caregiver burden and stress during active caregiving are well documented¹, far less is known about the post-caregiving period—particularly after the death of a care recipient². This transition often involves grief and significant identity disruption for caregivers whose roles were central to their self-concept. Understanding how former caregivers reconstruct identity is essential for advancing geriatric practice, bereavement care, and caregiver support services.

Methods: This qualitative study used Interpretative Phenomenological Analysis (IPA) to examine the experiences of eight former family caregivers of older adults (65+). Participants were recruited through purposive sampling. Semi-structured interviews explored their experiences before, during, and after caregiving ended. Data were analyzed using IPA's iterative coding procedures to identify themes, integrate reflexivity, and interpret meaning-making through Identity Theory, Caregiver Identity Theory, and the Meaning Reconstruction Model.

Results: Six superordinate themes emerged:

1. **Identity Transformation Through Caregiving:** Caregiving became a central and defining identity.
2. **Familial Duty and Moral Obligation:** Cultural values and reciprocity shaped caregiving motivations.
3. **Emotional and Physical Strain:** Participants reported cumulative stress, isolation, and burnout.
4. **Grief and Identity Disruption:** Caregivers experienced disorientation and loss of purpose after the care recipient's death.
5. **Long-Term Identity Reconstruction:** Meaning-making and benefit-finding supported identity rebuilding.
6. **Reflections and Wisdom for Future Caregivers:** Participants emphasized preparation, emotional openness, and realistic expectations.

Conclusion: Caregiving functioned as a transformative, enduring identity rather than a temporary role. Following the care recipient's death, the caregivers navigated a complex process of grief, role loss, and identity reconstruction. These findings highlight the need for post-caregiving supports, such as interventions on identity transition, clinician education on caregiver identity, and policies extending services beyond active caregiving. A more holistic understanding of the caregiving trajectory can strengthen geriatric practice and aging-service programs that serve former caregivers.

References:

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B84

Speaking the Same Care: Hospice Use by English vs. Non-English Language Groups with Dementia

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Background: In the US, 10% of adults aged ≥65 live with dementia. In 2022, 49% of Medicare beneficiaries used hospice services, of which 24% were persons living with dementia (PLWD). New York has the second lowest rate of hospice utilization (26%) of all states. Factors driving low hospice utilization are not fully understood. This study examined whether hospice eligible PLWD and limited English proficiency (LEP) had lower hospice utilization compared with hospice eligible English-speaking PLWD.

Methods: Retrospective EMR review of 401 patients admitted within a large health system from 1/1-6/30/2024. Inclusion criteria: age ≥18 and palliative care consult for goals of care. 358 patients

met inclusion criteria; 115 were PLWD and included in the analysis. Hospice referral and utilization rates were compared between LEP and English-speaking patients with dementia. To characterize the study outcomes and evaluate potential differences, descriptive statistics were utilized in conjunction with chi-square analyses. These comparisons were specifically performed based on participants' language status (LEP vs. English-speaking) and dementia status (dementia vs. no dementia).

Results: Among 115 PLWD, 26 (23%) had LEP and 89 (77%) were English-speaking. Comparing LEP vs English-speaking, 18/26 (69%) vs 54/89 (61%) respectively met hospice eligibility. Hospice referral rates (83% for LEP vs. 69% for English-speaking; p=0.22) and utilization rates (67% for LEP vs. 78% for English-speaking; p=0.38) did not differ significantly. Further analysis investigated hospice utilization within the LEP patient cohort, comparing individuals whose primary hospice diagnosis was dementia (10/15, 67%) to those with non-dementia diagnoses (25/34, 74%). Utilization did not differ significantly between these groups (p=0.62). Among English-speaking patients, hospice utilization was significantly higher in those with dementia 24/29 (81%) compared to those without dementia 24/46 (52%) (p=0.0076).

Conclusions: There was no difference in hospice utilization rates between LEP vs English-speaking. In contrast, English-speaking PLWD showed higher utilization than those without dementia. Future studies exploring the role of dementia as a primary diagnosis with a larger sample size would be needed to confirm these observations and inform approaches to increase utilization and understand the barriers to hospice utilization statewide.

B85

When ACP Falls Short: How Frailty, Isolation, and Language Barriers Drive Misaligned Care

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Background: Older adults with limited social support, low health literacy, and language barriers are at higher risk of receiving high-burden, misaligned end-of-life care. This case illustrates how social isolation and communication gaps undermine advanced care planning (ACP) execution, leading to unwanted interventions.

Case: An 84-year-old Spanish-speaking man with severe frailty, wheelchair dependence, and social isolation previously expressed DNR/DNI preferences, designated a lifelong neighbor as his health-care proxy (HCP).

Months later, he presented with dyspnea and was diagnosed with a hypopharyngeal mass. He underwent a non-emergent awake tracheostomy to permit planned chemoradiation. During this hospitalization, neither his HCP nor his Spanish-speaking primary care physician (PCP) were contacted despite an ACP documented in the electronic medical record. He was discharged to a nursing home (NH) due to secretion management needs. There, he became severely depressed, voiceless, unable to eat, desperate to return home. He was rehospitalized for failure to thrive, reaffirmed his code status as DNR/DNI and declined PEG placement, stating that the tracheostomy had already caused severe suffering. This time, his PCP was notified and visited throughout his hospitalization, facilitated meetings with HCP, and helped rebuild trust and clarify goals. Themes expressed through pen-and-paper communication included hopelessness, loss of dignity and quality of life in institutional settings. Later, he agreed to PEG placement if it could allow survival hoping to eventually return home. Four weeks later, he died at the NH.

Discussion: This case illustrates the difficulty of achieving goal-concordant care when ACP reviews are absent and the time-to-benefit of aggressive interventions in frail adults (e.g., chemotherapy) is overlooked. It emphasizes the critical role of language concordance, trusted relationships, and continuity with primary care in guiding serious illness decisions.

Conclusion: Recognizing isolation, language discordance, and institutionalization as risk factors for avoidable, harmful interventions should prompt timely reassessment of goals and involve advocacy partners. ACP is only as strong as the system that activates it. When surrogates and trusted clinicians are not engaged, misaligned decisions can occur, even when preferences are documented.

B86

U.S. Care Professionals' Perspectives of Barriers and Facilitators of MAID in Dementia

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Background: With expanding "Death with Dignity" legislation across the U.S., there is a need to examine care professionals' perceptions of facilitators and barriers to medical aid in dying (MAID) for persons living with dementia.

Methods: In this cross-sectional study, we recruited U.S. care professionals, through professional organizations (AGS, GSA, AAHPM, HPNA) and snowball sampling, for a survey regarding benefits and concerns of expanding MAID access to persons living with dementia.

Results: Participants (N=529) were 46 years old (SD=12.7), White (77.4%), female (66.3%), and well educated (90.4%, post-graduate education). The sample primarily included physicians (70.5%) specializing in palliative care, hospice, and geriatrics. Participants consistently agreed with benefits, including: 1) To maintain autonomy, control, and sense of self (82.3%), 2) To die in the manner they choose (82.1%), 3) To avoid the anxiety, pain, and distress than can come from dementia (79.7%), and 4) To avoid placing the burden of caregiving on family (71.2%). Participants expressed greater variability regarding concerns, including: 1) There are treatment options currently available for dementia (21.5%), 2) There could be a cure available for dementia soon (9.0%), 3) They could be in the early stages of the disease and not near death (66.7%), 4) The emotional burden on the family (57.7%), 5) This creates a "slippery slope" to involuntary forms of hastening death (58.5%), and 6) This might place pressure on vulnerable populations to elect MAID (74.2%).

Discussion: This is the first study to explore care professionals' views on MAID throughout the U.S. Our findings demonstrate that they generally agree about potential facilitators of MAID in dementia; however, there is a lack of consensus regarding potential barriers. This dissonance supports the need for further research, policy, and clinical guidelines regarding the option to expand access to MAID to persons with dementia.

B87 Student Presentation

Understanding Older Women's Perspectives Towards Messaging About Screening Mammography Cessation

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Background:

Screening mammography is not recommended in older women 75+ or with life expectancy <10 years. Many such older women continue to receive screening mammograms. This study aims to understand how older women responded to a message promoting screening cessation.

Methods:

This was part of a larger study involving an online, randomized controlled survey of women aged 65+. We described a hypothetical 75-year-old woman with multiple comorbidities and functional impairments. Participants then read a message about mammogram screening cessation, delivered by the hypothetical woman's primary care physician, a news story, or a close family member. The message mentioned guideline recommendations, false positives from screening, and over-diagnosis.

Participants rated their support for screening cessation in the hypothetical woman on a 7-point scale, grouped into 3 categories: 1-2 (pro-stopping), 3-5 (middle), and 6-7 (pro-screening), and were asked an open-ended question about their thoughts when reading the message.

We conducted a qualitative analysis to extract themes from the open-ended responses, stratified by the 3 categories.

Results:

2295 women read the message, 1831 provided relevant open-ended responses. Mean age was 72.7 years; 83% were non-Hispanic White.

Attitudes and beliefs about screening aligned with quantitative ratings on support for screening cessation (Table). Participants in the "middle" group were most likely to value patient autonomy and more often intended to seek more information about screening. Positive message reactions included agreement, appreciation for the information, and relief or gladness. Negative message reactions included disagreement, disbelief, mistrust, perceived manipulation, and perceived lack of caring or ageism.

Conclusions:

Older women who are ambivalent ("middle" group) about screening cessation tended to value patient autonomy and seek follow-up information. Coupling messaging with clinician counseling and additional information can augment the effect on reducing over-screening.

Category	Theme	Pro-screening (n=721)	Middle (n=775)	Pro-stopping (n=328)
Attitudes/beliefs	Pro-screening	239 (33.2%)	101 (13.0%)	17 (5.2%)
	Pro-stopping screening	13 (1.8%)	101 (13.0%)	103 (31.4%)
	Autonomy/choice is important	37 (5.1%)	69 (8.9%)	17 (5.2%)
	Age is important	49 (6.8%)	92 (11.9%)	62 (18.9%)
Intentions	Seek more information	42 (5.8%)	51 (6.6%)	2 (0.6%)
	Follow own doctor's advice	123 (17.1%)	170 (21.9%)	31 (9.5%)
Message reactions	Positive	28 (3.9%)	75 (9.7%)	69 (21.0%)
	Negative	315 (44.7%)	159 (20.5%)	34 (10.4%)

B88 Resident Presentation

Aging with Hepatitis B: lived experiences of older Chinese Americans in Northern California

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Background:

Chronic hepatitis B (CHB) affects an estimated 2.4 million people in the U.S., most of whom are non-U.S.-born. The burden of CHB among adults ≥65 remains substantial and is projected to persist through 2030. However, little is known about their lived experiences. To address this gap, we surveyed adults with CHB receiving care at a federally qualified health center (FQHC) in San Francisco.

Methods:

A bilingual (English/Chinese) cross-sectional online survey was administered to adults with CHB at North East Medical Services (NEMS). This survey was previously validated in an international English-only study. Of 2,218 individuals contacted, 213 responded, including 52 aged ≥65. Here, we present descriptive statistics for participants aged ≥65.

Results:

All 52 participants were born in China; 65% were male and 81% had a high school education or less. Surveys were completed in Chinese (79%) or English (21%). Most (69%) had lived with hepatitis

B virus (HBV) for >10 years. HBV testing was commonly prompted by a physician (65%) or community screening (15%). After diagnosis, 69% reported that family members were tested or vaccinated. Half (52%) were on antiviral therapy, and most treated individuals (59%) had taken medication for ≥ 6 years.

Reported challenges included managing fatigue (85% at least somewhat difficult), maintaining a healthy diet (75%), and accessing providers (71%). Conversely, most reported no difficulty avoiding alcohol (65%), smoking (67%), or affording labs/imaging (72%).

Disease disclosure was common within immediate families (92%) but limited with extended family (37%), close friends (29%), or coworkers (12%). Reasons for nondisclosure included fear of differential treatment, concerns about worrying loved ones, and stigma. Health-related mental impacts were notable: many endorsed fears of liver cancer (54%), shortened life expectancy (42%), or transmitting HBV (42%).

Conclusions:

Our survey findings underscore the critical role of healthcare providers and community screening in CHB diagnosis and family follow-up. These findings also highlight the need for comprehensive, geriatric, and culturally tailored approaches to improve quality of life, reduce stigma, and address the complex needs of older adults living with CHB.

B89 Student Presentation, Encore Presentation Distinct Plasma Profile in Severe Aortic Stenosis- Upregulation of PVR, Downregulation of CRELD1

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Background: Calcified aortic stenosis (AS) is a common valve disease prevalent in older patients associated with significant morbidity and mortality. Proteomic studies enable characterization of changes in plasma protein expression in severe AS and may provide insight into causative pathways and/or provide disease biomarkers.

Methods: Blood samples were collected from patients ≥ 75 years with normal left ventricular systolic function undergoing cardiac catheterization with either severe AS (n=17) or structurally normal aortic valves by echocardiography (n=12). Samples underwent immunoaffinity depletion of high-abundance proteins and were analyzed by liquid chromatography-tandem mass spectrometry (LC-MS/MS). Proteins were identified and quantified with Spectronaut v20 (Biognosys). Logistic regression with lasso regularization was used to model the probability of a sample belonging to an AS patient versus a control. Support vector machine (SVM) modeling assessed the predictive power of selected proteins.

Results: The mean age was 82 ± 6 years, 59% were female and 24% had diabetes. The mean aortic valve area in the cases was 0.7 ± 0.2 cm². 1,974 proteins were identified with 126 showing significant differences between groups (log2 fold change of < -0.6 or $> +0.6$; $p < 0.05$). Proteins upregulated in AS patients were involved in immune responses, lipid metabolism, metabolic signaling and biosynthetic/catabolic pathways. Downregulated proteins were more numerous and functionally diverse. Logistic regression demonstrated that higher levels of poliovirus receptor (PVR)/CD155, a type I transmembrane protein involved in the establishment of intercellular adherens junctions, and lower levels of Cysteine Rich With EGF Like Domains 1 (CRELD1), a protein linked to congenital heart diseases involving heart valves and septa, were significantly associated with severe AS. The selected proteins demonstrated strong predictive power in the SVM.

Conclusion: Plasma proteins involved in immune responses, lipid metabolism and biosynthetic/catabolic pathways were

differentially expressed in patients with severe calcified AS. PVR and CRELD1 were identified as the proteins most predictive of severe AS and could serve as biomarkers of AS.

B90 Student Presentation

Exploring the Physiological Effects of One Week Meditation-Influenced Plasma on Lifespan and Diabetic Phenotypes in C. elegans

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Background: Type II Diabetes mellitus (DMII) is a chronic metabolic disorder that affects millions worldwide and remains one of the leading causes of death. While disease management typically relies on pharmacological interventions and lifestyle changes, emerging evidence suggests that non-pharmacological approaches such as meditation may improve metabolic function and reduce disease severity. We tested the effects of plasma from DMII participants pre- and post-meditation on C. elegans lifespan, movement, and morphology under standard and high-glucose conditions.

Methods: Six conditions were tested: (1) control (CTRL), (2) pre-meditation plasma (PRE), (3) post-meditation plasma (POST), (4) control + glucose (CTRL+G), (5) premeditation plasma + glucose (PRE+G), and (6) post-meditation plasma + glucose (POST+G). Glucose was added at a final concentration of 80 μ M, and plasma from 11 DMII participants was used at 1% (v/v). Media and treatments were refreshed every 2 days. Lifespan assay was conducted in liquid culture by counting live worms every 2 days. For movement and morphology analyses, worms were cultured in solid Nematode Growth Medium (NGM) agar and recorded at day 7.

Results: Glucose exposure resulted in a reduction in lifespan. Movement analysis revealed a decrease in total distance traveled among glucose-treated groups. However, average speed and worm amplitude did not follow a consistent pattern. Morphological measurements showed increased length, width, and overall area in glucose-treated worms. In contrast, exposure to meditation-derived plasma, did not significantly affect lifespan, movement, or morphology parameters compared to the matched-groups.

Conclusion This study establishes a simple and reproducible C. elegans model of diet-induced metabolic dysfunction. Glucose exposure led to reduced lifespan and induced an obese-like phenotype. Although, the exposure of 1% (v/v) meditation-altered plasma had no significant protective effect on those parameters.

B91

Predicting behavioral and psychological symptoms in hospitalized patients with dementia using random forest

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Background: Behavioral and psychological symptoms of dementia (BPSD) represent heterogeneous non-cognitive manifestations affecting patients of dementia during disease progression. Current detection methods rely heavily on caregiver-reported assessments, introducing both measurement bias and respondent burden. Objective measurement approaches utilizing continuous, context-sensitive data, such as actigraphy and wearable sensors, offer potential solutions but remain insufficiently integrated into clinical practice, despite emerging evidence supporting their feasibility and utility. We investigated whether 24-h actigraphy-derived features of circadian rhythm, sleep, and activity indicators could predict BPSD. **Methods:** Fifteen hospitalized patients aged 60-86 years (mean Clinical Dementia Rating = 1.7) underwent 14-day actigraphy monitoring with concurrent BPSD

assessment using the Neuropsychiatric Inventory (NPI). We extracted thirteen objective measures including sleep onset time, wake up time, total sleep time, sleep efficiency, wake after sleep onset, and sleep latency, mesor, amplitude, and acrophase of cosinor analysis, and total daily, average 10s epoch, the highest 85th and 95th percentile activity amount. Three machine learning algorithms including support vector machine, decision tree, and random forest, were trained to predict BPSD (NPI ≥ 30). An over-sampling method was used for learning from unbalanced datasets. **Results:** The models demonstrated an accuracy of 97.87%. The feature importance metrics demonstrated that total sleep time emerged as the predominant predictor, followed by wake up time, amplitude, and sleep efficiency. The demonstration of random forest tree at the first split by top95 activity in a day below 110.98, collectively 63.9 % of observations as classifying the right label. **Conclusions:** This study establishes that using actigraphy-derived indicators of circadian rhythm activity, and sleep constitutes a clinically BPSD predictor alongside conventional sleep metrics. These objective, continuously measurable parameters offer advantages over episodic clinical assessments, enabling early identification of deteriorating patients before behavioral crises emerge. Future validation in other settings is warranted.

B92

Creation of a Virtual Age-Friendly Curriculum for Community Health Workers

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Background:

Community Health Workers (CHWs) are frontline public health workers who provide health education, outreach, and care coordination. CHWs serve older adults yet receive little training specific to their care. To address this gap, we created a virtual age-friendly care curriculum for CHWs to increase knowledge and confidence to care for older adults.

Methods:

Through a collaborative state-wide needs assessment, we identified topics and resources of greatest interest for CHWs. In 2025, we created an 8-hour asynchronous, free, module-based curriculum in a learning management system (LMS) anchored in the 4Ms of Age-Friendly Health Systems. Modules included videos, interactive activities, and downloadable resources written in plain language. Post-course evaluations collected learners' overall course rating (5-pt Likert scale), retrospective pre-post confidence and knowledge assessments (4-pt scale), and narrative feedback. Wilcoxon signed-rank tests assessed differences in confidence and knowledge.

Results:

In the first quarter, 24 learners completed the curriculum. Most learners (79%) were White, non-Hispanic, CHWs, and spent over two years in practice. Retrospective pre-post data showed significant improvement in confidence and knowledge for all 30 post-course evaluation questions ($p < 0.05$). Mean confidence and knowledge scores increased from 3.39 to 4.51/5 and 3.40 to 4.54/5 post-training, respectively. Areas of greatest change included applying 4Ms to older adult care, understanding residential models of care, and recognizing memory problems. Learners appreciated the self-paced curriculum and realistic scenarios and noted challenges with the LMS.

Conclusions:

Early data from our CHW curriculum shows improvements in confidence and knowledge regarding the 4Ms, which could increase the capacity of CHWs to provide age-friendly care. Additional data will help guide modifications and assess the effectiveness of the curriculum. Our CHW training model has applicability to other health-care and community members, and replicability potential in other states where CHWs provide front-line care.

B93

Including Family Caregivers as Part of the Health Care Team

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Background: Integrating family caregivers into the health care team is critical for their well-being and the care recipient's. Doing so can enhance communication, care coordination, patient and caregiver satisfaction, and reduce the risk of hospital readmissions. In 2022, the Administration for Community Living (ACL) released the *National Strategy to Support Family Caregivers*, an initiative to formally recognize and support caregivers. As part of that, the Caregivers As Partners in Care Teams (CAP-CT) program was launched to educate health care professionals to include family caregivers in a patient's care journey.

Methods: CAP-CT developed online and live trainings with a team from the University of California, San Francisco; University of California College of the Law, San Francisco; University of California, Irvine; Archstone Foundation; and ACL. The team contains experts in geriatrics, caregiving, medical-legal topics, and clinical education. CAP-CT has a National Steering Committee composed of health care professionals, community organizations, and caregivers with lived experience. We tracked training completions and delivered optional online surveys after each training to assess the training's impact on learners' knowledge and perceived impact on patient and caregiver outcomes.

Results: We launched a flagship training, *Foundational Skills for Engaging Caregivers in Health Care*, which teaches interprofessional care teams the essential skills needed to identify, engage, and support caregivers. Between November 13, 2024 and September 30, 2025, 754 individuals took our trainings (79% attended one of our live, virtual trainings) and were from 31 states or US territories. Post-training evaluation data show that 93% (of $n = 293$ respondents) reported that CAP-CT trainings increased their knowledge on this topic, and 92% (of $n = 302$ respondents) reported that trainings will help them improve patient and caregiver outcomes.

Conclusion: Findings suggest that CAP-CT's training is equipping health care teams with the knowledge and skills to include diverse family caregivers in care processes and connecting them to resources. CAP-CT will continue to expand its training curriculum and offerings, focusing on different care settings, such as the hospital and nursing home settings.

B94 Student Presentation

New Ways of Looking: Using Visual Thinking Strategies to Introduce a Strengths-Based Approach to Care of Older Adults at Home and in the Community

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Background: Visual Thinking Strategies (VTS) is a widely studied arts-based pedagogy shown to enhance empathy, observational skills, and tolerance for ambiguity in medical trainees. These are skills important to geriatric care, especially within the home. To explore VTS's impact in this context, we developed and implemented a longitudinal curriculum that integrates VTS principles with existing geriatrics training to address bias in the care of older adults at home. This abstract reports findings from the first year of implementation among geriatric medicine fellows at Johns Hopkins.

Methods: Using Kern's 6-step approach, we created a curriculum delivered across the 2024–2025 academic year to seven geriatric medicine fellows. This curriculum included a baseline needs assessment and six classroom and museum-based VTS sessions. Image-based reflective exercises were conducted at the beginning and end of the academic year. Reflective exercises were also implemented in

home-based clinical encounters. Reflections were collected using a Qualtrics survey and coded using a rubric adapted from VTShome.org. Two end-of-year focus groups were held to explore the perceived curricular impact, and a thematic analysis was conducted. This study was approved by the Johns Hopkins IRB.

Results: All fellows completed all study activities. Across image-based reflections, the proportion of fellows demonstrating consideration of multiple possibilities (the highest level of reflection in our rubric) increased by 50% from baseline to year-end. Simple or detailed observations on images and home visits increased by 37.5%. Thematic analysis of focus groups revealed enhanced observational skills, curiosity and improved recognition of bias. Fellows found equal value in all learning experiences.

Conclusions: Findings from this study suggest that fellows demonstrate meaningful shifts in both how they think about and how they describe older adults in their clinical care. Their written reflections evolved from brief, assumption-based statements to more complex, evidence-supported observations characterized by curiosity and tolerance of ambiguity. Future directions include expanding the curriculum to interprofessional learners across medicine, nursing, and public health, as well as exploration of the impact on homebound patients.

B95 Resident Presentation

Using Generative AI to Support Resident-Led Senior Center Education: A Pilot Initiative

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Background: Prior work has separately explored community-based service-learning for trainees and AI in medical practice and education. However, less is known about the utility of generative AI (genAI) in community engagement and professional development. This pilot study evaluated how internal medicine (IM) residents can apply genAI as an educational tool to deliver talks in a community-based geriatrics curriculum.

Methods: Second-year IM residents gave community health talks to older adults at local senior centers and were coached in the use of genAI tools to prepare their presentations. Instructions included a guide on prompt hygiene and iterating output to align with older adults' needs and community-based care. A post-survey assessed knowledge gained about aging-related health topics as well as competency in clinical genAI use and communication with older adults. The survey included multiple-choice, Likert-scale, and open-ended questions.

Results: Ten residents participated in this pilot community engagement activity and completed a post-survey (100% response rate). Likert-scale questions showed positive outcomes ("somewhat agree" or "strongly agree") across domains. 6/10 (60%) residents reported both improved knowledge of aging-related health topics and enhanced ability to communicate with older adults with varying health literacy. All residents (100%) felt more connected to the community, and 8/10 found the experience valuable for professional development. 8/10 (80%) of residents felt more confident creating structured prompts and iterating AI outputs, with 50% planning to use genAI more in clinical settings and expressing interest in formal AI education. Free-text responses noted AI tools improved efficiency in preparing patient-friendly materials, though outputs required close error-checking.

Conclusions: IM residents in this pilot study valued delivering health education using genAI and connecting with older adults in the community. To support scalability and collaboration, we created a Microsoft SharePoint folder for residents to share and access educational materials developed with genAI. This study highlights the potential of genAI to enhance resident engagement and learning in future community health initiatives.

B96

AI-Powered Immersive Encounter with an Animated Avatar Improves IPE Readiness From Static Vignette to Authentic Patient Interaction

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Background

A Fall 2024 pilot using a traditional written vignette with Adult-Gerontology Nurse Practitioner (AGNP) and Master of Social Work (MSW) students (n=16 after outlier removal) produced no significant change and a slight decline in SPICE-R2 total scores (4.21 to 4.08). Students requested more authentic patient interaction.

Objective

To evaluate if replacing the static vignette with a high-fidelity animated avatar (HeyGen platform) improves readiness for interprofessional practice.

Methods

In Fall 2025, 14 students (6 AGNP, 8 MSW; mean age 34.9 years, range 23-54) each interacted individually for 30 minutes with an AI-powered animated avatar portraying Maria Gonzalez, a 72-year-old Latina woman with poorly controlled diabetes, recent fall, unresolved grief, family conflict, and financial hardship. Students then collaborated on care planning and presented in grand rounds. The validated 10-item SPICE-R2 was administered pre- and post-intervention and compared to the 2024 static-vignette cohort (n=16; mean age 33.2 years, range 26-47).

Results

Only the 2025 animated-avatar cohort (n=14) showed significant improvement. Overall SPICE-R2 total score rose from 4.11 to 4.52 (paired t-test p=0.004, Wilcoxon p<0.01, Cohen d=0.68, medium-large effect). Teamwork/Team-based Practice improved from 4.18 to 4.56 (p=0.012), Roles/Responsibilities from 3.95 to 4.41 (p=0.008), and Patient Outcomes from 4.20 to 4.58 (p=0.021). The 2024 cohort showed no significant changes on any factor.

All 14 students (100%) rated the assignment worthwhile. Real-time Spanish dialogue and emotional responsiveness enabled disclosure of hidden issues (faith-related suffering, familismo values, grief) that never emerged with the static vignette. Students described the encounter as life-like and transformative. Perceived ease of taking routine medications dropped sharply from 4.30 to 2.50 (p<0.01), confirming newfound empathy for the burden of complex geriatric regimens.

Conclusion

A high-fidelity animated avatar reversed a previously neutral-to-negative IPE experience and produced large gains in interprofessional readiness and medication-related empathy.

Implications

Commercially available animated-avatar platforms create scalable, emotionally authentic patient encounters that dramatically outperform static vignettes and warrant rapid adoption in geriatric IPE curricula.

B97 Student Presentation

Evaluating the Impact of Simulation-Based Training on Family Caregivers of Persons Living with Dementia

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Background: Most people living with dementia receive care at home, often from nonpaid family members and friends who lack formal training in essential caregiving skills. With an estimated 7 million Americans aged 65 and older currently living with dementia, this number is expected to double by 2060, along with the burden on caregivers. This study aims to examine the impact of simulation-based

training on enhancing caregivers' ability to provide care and assistance for their loved ones with dementia during Activities of Daily Living (ADLs).

Methods: An experiential design utilized a 2.5 hour in-person training that consisted of video-based instruction, hands-on simulations, and debriefing for caregivers of persons with dementia. Caregivers were recruited from free community dementia education programs. Simulations focused on ADL functions such as bathing, grooming, toileting, mobility, and transfers. The in-person training was conducted at UNT Health's Regional Simulation Center in Fort Worth, Texas. Pre- and post-surveys assessed confidence and emotional preparedness to provide care for their loved one with dementia using a five-point Likert scale across eight questions.

Results: There were 18 participants, including 13 females, and most were aged 65 or older. Responses to the pre and post survey questions noted improved confidence in assisting with mobility and transfers (33% to 88%), applying effective communication strategies (62% to 94%), comfort in performing personal care tasks for their loved one (33% to 100%), preparedness to be able to provide compassionate care to a bed-bound patient (23% to 70%). Caregivers' sense of being equipped to support emotional and physical needs of their loved one also increased (50% to 82%). A strong sense of compassion for their loved one with dementia increased (67% to 94%) along with empathy (6% to 29%).

Conclusion: The use of simulation-based training had a significant impact on the participants' confidence, knowledge, skills and emotional readiness in caring for their family member with dementia. The training was perceived as meaningful and transformative, paving the way for innovative caregiver trainings that use hands-on simulation training to better prepare caregivers to assist a person with dementia with their ADLs.

B98 Encore Presentation

Expanding the Impact of the Driving and Dementia Roadmap Through a National Radio Ad Campaign

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Background: People with dementia (PWD) and family/friend carers (FCs) feel ill-equipped to manage the driving cessation process in dementia. Our online platform, the Driving and Dementia Roadmap (DDR) (www.drivinganddementia.ca) – accessed by over 43,000 users to date – provides knowledge, resources and tools to help manage this process and provide support for when driving stops. The present objective was to explore the impact of a national radio ad campaign to expand the uptake of the DDR.

Methods: In January 2024, radio ads targeting PWD and FCs were broadcast to 5 Canadian provinces. Excluding regions with less than 4 users in January 2024, a total of 43 regions received the radio ads (coverage regions) and 39 regions did not (non-coverage regions). Google Analytics of the DDR were collected in January 2024 (broadcast period) and September-December 2023 (pre-broadcast period). Four outcomes were compared to assess the interaction between time (broadcast, pre-broadcast) and coverage (coverage, non-coverage) that would indicate a greater uptake of the DDR associated with the radio ads: total users, new users, return users, and engaged sessions (i.e., visits > 10 seconds). Data were analyzed using population size-adjusted Poisson regressions for each outcome.

Results: The interaction between time and coverage was non-significant as there were no significant differences (all p's>.05) between coverage and non-coverage regions when assessing the difference in each outcome between broadcast and pre-broadcast periods. However, when assessing each outcome using exploratory analyses in the broadcast period, new users (Incidence Rate Ratio [IRR]=1.58,

p=.01) and engaged sessions (IRR=1.45, p=.04) were significantly greater within the coverage regions compared to non-coverage regions.

Conclusion: This national radio ad campaign had a significant impact on the uptake of the DDR, associated with a greater number of new users and engaged sessions in the month they were broadcast. Overall, this expanded uptake will help an increased number of PWD and their FCs access the knowledge, resources, and tools needed to better manage the complex process of driving cessation.

B99

Real Time Researcher: Leveraging Technology and Learner Drive to Accelerate Confidence in Evidence Based Practice

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Background: Evidence based practice (EBP) integrates clinical expertise with the current best evidence. Practicing EBP can be particularly difficult in certain fields of medicine like Geriatrics where guidelines and published evidence is lacking for the specific population and clinical situation. Clinical informatics (CI) platforms allow physicians to answer research questions using aggregate patient data to bridge the evidence gap. The Atropos Health CI platform helps navigate clinical questions using observational data with propensity score matching with support from a clinical informaticist. While traditional EBP curricula focuses on accessing existing evidence, such as journal club, a more active approach using CI to answer self-directed clinical questions can increase intern knowledge of EBP.

Methods: We implemented a project-based intervention for Internal Medicine interns on their two-week Geriatrics rotation to practice EBP skills utilizing a CI platform through Atropos Health. Interns simultaneously submitted a clinical question through the platform and queried the traditional literature base. The impact of the project was evaluated through a pre and post intervention survey composed of a case-based question to assess practice behavior and self-reported confidence in EBP components on a 5 point Likert scale (1-least confident, 5-most confident).

Results: Data was collected between 7/2024-8/2025 amongst 47 interns. Pre-post matched de-identified data was obtained for 23 interns (49%). Practice behavior shifted away from immediate pharmacologic treatment. Confidence increased across all EBP components (Table).

Conclusions: We describe an innovative project-based curriculum for interns utilizing CI to teach EBP. This novel, active curriculum was effective in increasing confidence across multiple EBP skills, particularly practicing in situations of clinical uncertainty. Ensuring physicians are trained in EBP will help care for a geriatric population which is less represented in traditional evidence.

Confidence in Evidence Based Practice (EBP) Skills

EBP Skill	Recognize a knowledge gap	Formulate a question	Access existing evidence	Appraise the evidence	Apply to practice	Assess efficacy	Practice in uncertainty
Pre-intervention Mean (SD)	3.4 (0.6)	3.6 (0.8)	4.0 (0.5)	3.5 (0.9)	3.8 (0.4)	3.2 (0.6)	3.0 (1.1)
Post-intervention Mean (SD)	4.1 (0.1)	4.2 (0.3)	4.3 (0.4)	4.1 (0.6)	4.2 (0.3)	3.7 (0.5)	3.9 (0.6)
p-value	0.0001	0.003	0.08	0.001	0.009	0.01	0.0008

B100

Geriatrics Escape Room In Internal Medicine Residency AM Curriculum Enhancement (GERI-IM.RACE)

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Background: While escape rooms are a popular way to improve learner satisfaction in medical education, evidence of knowledge retention or application is lacking per a recent systematic review (10.1007/s40670-024-02270-y). In Geriatrics, escape rooms have been used in longer formats (>2 hours) that may limit their incorporation into busy residencies. Here, we combined a Geriatrics-themed escape room and lecture into the usual Internal Medicine (IM) AM resident curriculum setting. Study outcomes include assessment of knowledge and comfort.

Methods: The educational intervention consisted of a pre-activity survey, participation in an escape room (20 minutes), and—following a 5-minute debrief—a 30-minute interactive lecture and post-activity survey (~one hour total). Residents split into 3 groups and performed a comprehensive geriatric evaluation corresponding to 3 (Medications, Mobility, and Mind) of the 5Ms Criteria. The activity involved pill bottles, office notes, physical locks (with codes corresponding to correct answers), and atmospheric music. Knowledge transfer was assessed with identification of 10 potentially inappropriate medications (PIM), 8 ADLs/IADLs, and 5 risk factors for falls (all true/false). Comfort level was assessed via a 4-point scale.

Results: For the initial 2 of 5 sessions—totaling 29 of 71 possible residents who participated thus far—96.6% completed the surveys (n=28 analyzed). Comfort levels in management improved 57% to 93% for polypharmacy (p=0.002), 61% to 94% for identifying dementia (p<0.001), and 43% to 86% in treating a post-fall patient (p=0.003). PIM identification improved 67% to 74% (p=.007), ADL/IADL recognition improved 69% to 93% (p<.001), and fall risk factor identification improved 50% to 84% (p<.001). Feedback themes included engagement (n=4) and lack of clarity in instructions (n=2).

Conclusion: This study incorporating a geriatric escape room and lecture into an existing graduate medical education curriculum structure demonstrates high engagement while providing evidence of significant knowledge transfer. We will assess retention with a one-month post-intervention survey, and clinical application via evidence of 3Ms screening in resident clinic notes. Future work assessing escape room plus lecture versus lecture alone will help guide incorporation of the 5Ms into IM resident education curricula generally.

B101 Resident Presentation

Evaluation of an older adult medical school alumni mentorship program for students to learn about aging

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Older adult mentor programs offer a way for medical schools to prepare future clinicians to care for our aging population, including tools for avoiding the negative health impacts of ageism. AGE-PAIRS (Aging and Geriatrics Education: Physician Alumni Intergenerational Relationships with medical Students) is a novel mentor program that involves matching medical school students with older adult medical school alumni mentors. AGE-PAIRS was conducted at Harvard Medical School in 2024-25, and consisted of bimonthly student-mentor dyad calls focused on 4 topics (medicine as an evolving profession, perceptions of aging, retirement, ageism) with associated pre-readings

or podcasts. The program was evaluated using focus groups, student surveys and reflection pieces, and a pre- and post-program survey that assessed attitudes towards aging using an adaptation of the validated COCOA questionnaire. 148 medical student-mentor dyads participated in AGE-PAIRS. Attitudes to aging on the pre-program survey were very positive, and stayed stable or improved slightly on the post-program survey. 78% mentors reported that the program was moderately, very, or extremely effective and 84% students report excellent or very good program experience. In addition, 83% of students reported having an excellent or very good match as did 81% of mentors. 92% of mentors would like to participate again. Qualitative analysis of the student reflections revealed 5 parent themes for discussion: changing workforce, changes in medicine, changes with aging, professional growth, and relationships (Table 1). AGE-PAIRS is a highly-rated educational program that provided a balance of career advising from older alumni and insight into the aging experience for medical students, and offers a powerful model for preparing students to care for older adults with empathy and excellence.

Summary of qualitative thematic analysis of student reflections completed after each call

Parent Themes	Sub-Themes	Sample Quote (Call #, Entry #)	N (%)
Changing Workforce	Workforce Diversity, Opportunities	"She mentioned graduating and being unable to find a job due to her race, having to start her own private practice. It's unacceptable that she had to go through this, but it shows how far we've come and how far we still need to go." (Call 4, Entry 27)	43 (18%)
Changes in Medicine	Tech, Curriculum, Sub-specialization	"We discussed...how medical training has changed, including the responsibilities of medical students, whereby there is more structured learning and more safeguards for patients as well as for students." (call 1, Entry 3)	114 (47%)
Changes with Aging	Physical, Mental, Ageism	"It was inspiring to see that even in her late 80s, my mentor is still attending conferences, participating in the community, and only occasionally uses a cane." (Call 2, Entry 9)	124 (51%)
Professional Growth	Work-Life, Identity	"We both agreed that doctors who demonstrate empathy, who are willing to listen to the holistic life story of a patient, and who appreciate their values and concerns take priority over doctors who simply know more information." (Call 3, Entry 29)	54 (22%)
Relationships	Peers, Intergenerational	"Dr. [X] talked about the powerful friendships she made in medical school, and how many of those relationships continue to this day." (Call 2, Entry 34)	63 (26%)

n = 242

B102

Third Year Medical Student Geriatric Focused Education Via Objective Structured Clinical Examination (OSCE)

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Background: Shifting demographics indicate an increase in older patients with chronic illness and medical complexity, highlighting the need for all medical trainees to learn core geriatric principles. There is national consensus that all medical students should graduate with core geriatric competencies given that most geriatric care will be provided by primary care providers and all trainees will interface with older adults in their chosen specialty. Medical schools are seeking ways to incorporate geriatric education across the 4-year curriculum. Geriatric education can be integrated into the Family Medicine Clerkship (FMC) to expand its delivery, via a geriatrics focused OSCE case within the FMC. **Methods:** FMC medical students complete an OSCE with 3 cases at the end of each 6-week rotation virtually with standardized patients (SPs) with 1 case focused on falls. Students are assessed by SPs with 9 questions related to falls evaluation and management. Student scores were collected from April 2020-October 2025. FMC orientation includes an hour long lecture on 5Ms.

Results: 1461 student assessments were reviewed for analysis. 99% of students asked about fall risk factors and discussed management options for fall prevention. 96% reviewed medications. 55% asked about patient's functional status; 70% asked about use of assistive devices and 87% about history of other falls. **Conclusions:** Geriatric education was integrated into an FM clerkship through use of a falls case during the OSCE. The results demonstrate effective geriatric education about falls, with students performing overall very well.

Results highlight an opportunity to emphasize functional assessment, included in the mobility section of the 5 Ms.

Functional status has many implications including patient safety, QOL and prognosis. This OSCE offers an example of a targeted, feasible opportunity to integrate geriatrics specific learning in the FM Clerkship curriculum, in order to increase student learning while in undergraduate medical training. Analysis of performance serves as an opportunity to address other gaps in geriatric education during FM clerkship.

B103

Palliative Care Skills Training: A Scalable Method to Build Age-Friendly Skills for Clinicians

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Background: The CMS Age-Friendly Measure was designed to provide clinicians with a framework to improve care for older adults by focusing on the 4 Ms (What Matters, Medication, Mentation, and Mobility), and relevant training is needed. Virtual clinical education focusing on palliative care skills can help address this pedagogical need.

Methods: The Center to Advance Palliative Care (CAPC) created an Age-Friendly learning pathway designed for interprofessional clinicians and a designation to demonstrate overlap between age-friendly and palliative care skills. The pathway contains 7 interactive courses offering continuing education (CE), 2 games focused on reducing medication load and treating delirium, and 7 additional resources.

Results: Since 2023, a total of 421 clinicians from at least 5 disciplines and 11 specialties completed the pathway, earning Age-Friendly Care designation. Learners work for varied organizations; 65% are employed by hospitals, 12% by home care/hospice agencies, 9% in private practices, and 14% from other settings. Nurse practitioners made up almost a third (29%) of learners; social workers (20%) and registered nurses (17%) completed the top three disciplines. Almost two-thirds of learners (62%) worked in non-palliative care specialties.

Conclusions: The Age-Friendly virtual learning pathway is an effective and efficient way to reach large groups of interprofessional clinicians in multiple health care settings nationally and uses established palliative care skills training to enhance geriatric care competencies in managing medications, addressing cognitive issues, optimizing mobility, and treating pain.

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B104

Collaboration is Key: Unlocking the Power of Play to Improve Understanding of Geriatrics Interprofessional Teams

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Background: Educational Escape Rooms (EERs) which utilize modalities of game-based learning have been shown to promote learner engagement and motivation while enhancing knowledge and fostering teamwork and communication. We created a two-hour EER for health profession trainees (HPTs) to learn about the 4Ms of Age

Friendly Care and to illustrate how a care plan informed by multiple disciplines actualizes the coordinated, patient-centered care of the 4Ms model. We assessed learners' understanding, confidence and experience of this interprofessional EER.

Methods: EERs precepted by multiple interprofessional disciplines were held annually from 2022-2025 within a VA Health Care system. HPTs were surveyed before and after the escape room. 10 items ascertained understanding of developing care plans and how different disciplines contributed to the care plans. The items were rated on a 5-point Likert scale and then were summed to create a pre- and post-total score (10-50). A paired sample t-test was used to test for differences in pre and post total scores. Other items administered after the EER assessed confidence in participating in an interprofessional team for older adults and overall assessment of the pedagogical strategy.

Results: Over a span of three years, 87 HPTs participated in the EER representing multiple disciplines including medicine, pharmacy, optometry, occupational therapy, social work, audiology, and chiropractic medicine students. Pre and post data were obtained for 85 out of 87 students. The mean increase in total score was 8.89 points, representing a large effect size for the EER (Cohen's d = .120 [95% CI: .92, 1.47]). Most participants reported improved confidence in working on care teams (68%) and integrating the 4Ms into a care plan (92%). Overall, the training was well received with 92% endorsing that the training was a relevant learning experience and 94% reporting they would recommend it to others.

Conclusion: This EER designed to increase familiarity with evidence based interprofessional care for older adults amongst HPTs was well received and significantly improved understanding of how an older adult's care is informed by different disciplines. This EER is an important first step in training HPTs to work in geriatrics interprofessional teams.

B105

Distinct Clinical Features of Nonagenarians with Atrial Fibrillation

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Background: Studies on atrial fibrillation (AF) in the very elderly population (≥ 90 years old) are crucial due to high prevalence of AF in this age group and their distinct clinical characteristics. Research focusing on these patients, particularly those who have never used oral anticoagulants (OACs), is especially valuable as it helps to eliminate the confounding effects of OAC use, providing clearer insights into AF clinical features in this vulnerable population.

Methods: A retrospective hospital-based cohort of 12,911 AF patients who had no history of stroke and never used OAC were longitudinally followed up for up to 5 years. Among them, 753 nonagenarian AF patients (≥ 90 years old) were selected as our study population. The primary outcome was hospitalization for ischemic stroke.

Results: The entire cohort was comprised of individuals from Taiwan. Compared to patients under 90 years old, nonagenarian AF patients were more likely to be female (57% vs 42%) and more had history of hypertension, congestive heart failure and fewer coronary artery disease. Although stroke rates increased with age, they peaked between 70 and 89 years old and did not rise further in those ≥ 90 . No clinical factors, except history of hyperthyroidism, were significantly associated with stroke risk in nonagenarian AF patients. CHA2DS2-VASc score was also not predictive of stroke risk in nonagenarian OAC-naïve AF patients (hazard ratio [HR] 0.97 [95% confidence interval 0.77-1.21], $P=0.794$). However, hyperthyroidism was associated with a 2.6-fold increase of stroke risk (HR 2.60 [1.04-6.49]), $P=0.041$).

Conclusions: In OAC-naïve AF patients, the stroke rate did not increase further after 90 years of age. Among these very elderly AF patients, it was not CHA2DS2-VASc score but history of hyperthyroidism that was associated with an elevated stroke risk. This finding suggests that hyperthyroidism should be considered in stroke risk assessments for the very elderly AF population.

B106 Resident Presentation

Validation of Electronic Frailty Index Among Surgical Patients

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Background: Interest in identifying frailty pre-operatively to prevent adverse outcomes is growing, yet there are insufficient resources to clinically assess all patients. Electronic frailty indices using routinely collected data can help identify older adults who would most benefit from a Geriatrician's assessment.

Methods: We compared results of an electronic frailty index (MGB-eFI) with a clinician performed Comprehensive Geriatric Assessment (CGA-FI) among a convenience sample of surgical patients seen 11/2019-11/2024 at a regional academic medical center. We identified patients who had a CGA-FI performed by a clinician and extracted diagnostic and procedural factors from a centralized data registry to calculate the MGB-eFI. The CGA-FI was divided into non-frail ≤ 0.2 , frail 0.2-0.4, and severely frail > 0.4 . We calculated mean MGB-eFI by category and Spearman's correlation with CGA-FI. Additionally, we evaluated the performance of the MGB-eFI as a screening test with a score > 0.2 defining a positive result.

Results: 59.8% of the 351 patients in the sample were female with a median age of 83 (IQR 78-88). 88.3% of patients in the sample were White. Among non-frail, frail, and severely frail patients mean MGB-eFI scores were 0.196 (SD 0.085), 0.285 (SD 0.100), and 0.373 (SD 0.119) respectively. The MGB-eFI was positively correlated with the CGA-FI ($r = 0.54$, $p < 0.001$) and demonstrated a sensitivity of 0.62 and specificity of 0.78. In the sample, where 71% of the population was considered frail or severely frail, this corresponded with a negative predictive value of 0.83.

Conclusions: Our results support the construct validity of the MGB-eFI by establishing similar determinations of frailty via MGB-eFI as those identified by CGA-FI. Our findings also support use of the MGB-eFI as a screening tool to rule out patients who may be less likely to exhibit clinical frailty.

B107

Relational Strain and Emotional Dynamics Among Spousal Caregivers During the Perioperative Period of Older Adults Undergoing Major Elective Surgery

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Background:

Older adults undergo a large proportion of major surgeries and face elevated postoperative risks due to physiologic decline and multimorbidity. Spouses frequently serve as informal caregivers, yet research has focused mainly on logistical rather than relational aspects of perioperative caregiving. The perioperative period represents a psychologically demanding time marked by uncertainty. This study explored interpersonal dynamics contributing to caregiver strain among spousal caregivers of older adults undergoing major elective surgery.

Methods:

This qualitative study was nested within a larger investigation at the University of California, San Francisco examining psychosocial needs in older adults (≥ 65 years) undergoing elective surgery. English-speaking family caregivers aged ≥ 18 years were recruited using convenience sampling. Semi-structured telephone interviews were conducted at three timepoints: within two weeks preoperatively and one and three months postoperatively. Interviews were recorded, transcribed verbatim, and analyzed inductively using thematic analysis following COREQ guidelines. Two coders independently reviewed transcripts and refined themes through iterative discussion until thematic saturation was achieved. The UCSF IRB approved the study (IRB #19-28391).

Results:

Thirteen caregivers (mean age 67 ± 10.7 years) completed 27 interviews. Most were female spouses who identified as White with some college education. Care recipients underwent diverse surgeries, most commonly for cancer. Three primary themes emerged: (1) *Discordance in treatment preferences and surgical goals*; (2) *Unmet recovery expectations*—disappointment occurred when recovery trajectories did not meet hopes; and (3) *Persistent relational negativity*—ongoing emotional volatility from patients intensified caregiver exhaustion. These findings reveal that perioperative strain affects communication and relationship stability.

Conclusions:

Spousal caregivers of older surgical patients experience relational strain driven by misaligned expectations and emotional volatility. Clinicians should assess dyadic readiness as part of preoperative planning. Integrating resilience-based and behavioral activation frameworks may improve relational well-being and postoperative recovery for both partners.

B108

Updated Geriatrics Competencies for Residents

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Background Given population aging, Internal Medicine (IM) and Family Medicine (FM) residency programs must incorporate geriatrics training to prepare physicians to deliver high-quality care to older adults.

Methods From 2022–2024, a working group of 15 geriatrics, IM, and FM leaders used a modified Delphi process to revise the 2010 competencies, emphasizing observable, evidence-based behaviors aligned with the Geriatrics 5Ms. Final revisions incorporated iterative workgroup review and results from a national survey of geriatrics faculty and IM/FM program directors.

Results A total of 153 respondents completed the national survey, including 92 geriatrics experts (16.8% response rate) and 61 IM/FM residency program directors (4.8% response rate). All 25 updated competencies reached $\geq 70\%$ agreement among geriatrics experts (71.1%–97.8%), and 22 reached this threshold among program directors (64.8%–98.3%).

Conclusions These updated geriatrics competencies offer an evidence-informed framework to strengthen residency training and prepare physicians to deliver age-friendly care.

Table 1. Updated minimum competencies in Geriatrics for Internal Medicine and Family Medicine residents, developed by the American Geriatrics Society. As most patients cared for by IM/FM residents are adults aged ≥65, graduating residents must demonstrate

MIND
Cognitive concerns: In an older adult with concerns regarding cognition or mood, perform and interpret an appropriate assessment to distinguish normal aging from other conditions, including dementia, delirium, mood disorders, substance use disorder, and address the interactions among them.
Capacity: Determine if an older adult has capacity for making a medical decision, and if not, identify and engage the legal surrogate decision maker.
Delirium: Recognize that delirium is a medical emergency; as such, diagnose, initiate workup for precipitating factors, and treat underlying causes. Mitigate risk factors for hospitalized older adults.
Agitation management: When managing an older adult with confusion and disruptive behaviors, identify and treat reversible causes of agitation. Collaborate with an interprofessional team to identify treatment strategies that minimize the use of pharmacological and physical restraints.
MOBILITY
Functional assessment: Perform a functional assessment in an older adult that includes basic and instrumental activities of daily living. Collaborate with appropriate interprofessional team members to optimize the older adult's functional status, especially during hospitalization, transitions of care, and post discharge follow-up.
Mobility assessment: Perform and interpret a gait and balance assessment using validated screening tools, and screen older adults for intrinsic and extrinsic fall risk factors.
Fall and fracture risk reduction: Identify older adults at increased risk of falls or fractures, and develop a multicomponent plan to mitigate risk, in collaboration with appropriate interprofessional team members, that may include, but is not limited to, physical and occupational therapy, assistive devices, medication review, environmental modification, optimization of vision and management of bone health.
MEDICATIONS
Deprescribing: Perform a review of the older adult's medications (prescribed and non-prescribed) and deprescribe those that are duplicates or potentially inappropriate, high risk, or lack a current indication. When appropriate, discuss alternatives, ways to decrease adverse effects, and develop a monitoring plan.
Adherence and deprescribing: Identify and address barriers to adherence. When appropriate, discuss alternatives and ways to decrease adverse effects.
Geriatric pharmacology: When reviewing or prescribing medications, justify drug selection and dosing based on 1) how age-related physiologic changes may impact drug pharmacokinetics and pharmacodynamics; and 2) how the older adult's comorbidities, functional status, and other medications may increase the risk of side effects.
Prescribing cascades: Determine whether a new symptom in an older adult may be due to a medication adverse effect, drug-drug interaction, and/or drug-disease interaction, and modify the treatment plan as needed to avoid a prescribing cascade.
MULTICOMPLEXITY
Aging physiology: Account for the interaction of age-related physiological changes and co-morbidities when evaluating and developing treatment plans for older adults.
Atypical presentations: Identify conditions that may present differently as people age or as geriatric syndromes, when developing differential diagnoses and treatment plans.
Frailty: Define and apply appropriate tools to assess frailty in older adults and incorporate this into clinical decision making.
Nutritional status: Assess an older adult's nutritional status, identify underlying causes for weight and body composition changes, and develop initial management plans, including involvement as appropriate of interprofessional team members, specialty consultants, and caregivers.
Sensory impairment: Identify if an older adult has difficulty with hearing, vision, and/or speech, and include interprofessional team members, specialty consultants, and caregivers in a person-centered treatment plan.
Safety and autonomy: Identify when older adults are in a potentially unsafe situation, which may include, but is not limited to living environment, caregiver stress, elder mistreatment, self-neglect, or at-risk driving. Collaborate with interprofessional team members and caregivers to balance safety and autonomy.
Health equity: Define ageism and identify how it intersects with racism, sexism, and other forms of bias to negatively impact the health of older adults. When caring for older adults, assess for experience of discrimination, identify relevant social determinants of health that may contribute to health disparities, and develop holistic care plans to promote equity in access and quality of care for older adults and their caregivers.
Hazards of hospitalization: Identify and act to reduce hazards of hospitalization and promote safety for an older adult during inpatient stays and transitions of care.
Transitions of care: Coordinate and document a safe, person-centered care transition, considering the older adult's preferences, baseline and current functional and mental status, advance care plan, and need for community-based resources.
MATTERS MOST
Patient Priorities: Ask what matters most to each older adult and individualize treatment plans and preventive care recommendations in the context of these priorities, prognosis, function, and cognition.
Communication: When communicating with older adults and their caregivers, demonstrate cultural humility and use their preferred language, self-identifiers, and pronouns. Adapt communication strategies to the older adult's cognitive abilities and setting.
Advance care planning: Lead a person-centered discussion and document health care proxies, advance directives, and life-sustaining treatment orders, in the context of the laws of the state in which one is training.
Psychosocial and spiritual needs: Incorporate the psychological, social, and spiritual needs of an older adult into their care, including caregivers and interprofessional team members as appropriate.
Symptom assessment: Manage pain and other symptoms in an older adult, considering comfort and function, utilizing non-pharmacologic and pharmacologic treatments, and collaborating with interprofessional team members as appropriate.

B109

Clinical Outcomes in Geriatric Hip Fracture Patients With and Without Dementia Following Ground-level Falls

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Background: People 65 years and older with hip fractures have high rates of morbidity and mortality after hospital discharge. The presence of dementia portends an even greater risk, highlighting the importance of early discussions of goals of care. The aim of this study is to examine clinical outcomes in patients with isolated hip fractures following ground level fall, with and without dementia, to aid in these discussions.

Methods: This retrospective study used medical records and trauma registry data from our institution, which is the highest volume Level 1 trauma center in the state for hip fractures. Patients aged 65

and older with isolated hip fractures from ground-level falls between January 1, 2018, and October 20, 2024 were included.

Results: 2121 geriatric trauma patients, 509 with dementia (mean age, SD: 85±6.8) and 1612 without dementia (mean age, SD: 80±8.6) were identified. 96.4% of the population was Caucasian, and 68% were female. Patients with dementia were more likely to be female, older, have higher baseline functional dependence (61.9% vs 47.4%; p<0.0001), lower operative fixation rates (94.1% vs 96.2%; p<0.05), and higher incidence of delirium (4.9% vs 2.7%, p<0.05). Readmission at 30 and 90 days was lower (p<0.03 and p<0.004) in the dementia group. Advance care planning discussions, DNR orders, and health-care power of attorney documentation were all significantly higher amongst patients with dementia (all p<.0001). Patients with dementia were significantly more likely to have a hospice consultation and be discharged to hospice (p<0.0001). Mortality rates were significantly greater for patients with dementia at all points assessed (in hospital, 30, 60, 90, 180, and 365-days post-discharge, all p<.0001).

Conclusions: Patients with dementia have higher mortality rates at all time points measured post-discharge than those without. These findings highlight the importance of early care planning, including discussing prognosis, patient preferences, and advanced care planning during hospitalization for this population. Multidisciplinary collaboration, including engaging Geriatrics as is routine at our institution, can be beneficial in guiding these important discussions.

B110 Student Presentation

Enhancing Atrial Fibrillation Detection in Geriatric Trauma

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Background: Atrial fibrillation (AF) is common in geriatric trauma patients (GTP) and linked to worse outcomes, yet AF monitoring/detection practices are inconsistent. This study identifies risk factors for AF with rapid ventricular response (AF-RVR) to guide EKG and telemetry use.

Methods: Prospective observational study (June 2024–May 2025) in two Level I trauma centers using a standardized cardiac monitoring protocol with initial EKG for all GTP and telemetry >72 hours for high-risk patients. Daily chart review and provider communication were performed.

Results: A total of N=1305 patients were included. Average age was 73.36 ± 10.28, and 52.8% were male. Overall, 166 GTP had a diagnosis of AF: 33 (20%) new-onset AF (New-AF) and 133 (80%) with a prior history of AF (Prior-AF). Eighty-six GTP experienced active AF-RVR requiring pharmacologic intervention (6.6% of the cohort; 51.8% of patients with New-AF or Prior-AF). Predictive factors in New-AF were CHF history, CKD or ESRD (OR=2.68[1.18-6.06]), 2.35[1.87-6.34 and 6.73 [1.45-31.87], respectively), transfusion requirement (OR=3.5[1.72-7.18]), surgery to thorax (OR=11.05[2.95-41.35]) or abdomen (OR=6.1[1.32-28]), intraoperative blood loss > 500cc (OR=6.01[1.98-18.26]), current smoker (OR=2.18[1.04-4.55]), or radiographic cardiomegaly (OR=3.38[1.3-8.75]). In Prior-AF patients, CHF, transfusion requirement, and radiographic cardiomegaly (OR=3.19 [1.68–6.06], 2.26 [1.73–4.11], and 10.11 [4.84–21.13], respectively) remained significant predictors. Insulin-dependent diabetes mellitus (IDDM) conveyed additional risk (OR=2.15 [1.05–4.39]). Most patients were treated medically. Thirty-two non-medical interventions occurred: 19 in New-AF and 13 in Prior-AF (including 9 cardioversions, 6 pacemaker or Holter monitor placements, 4 CPR/ACLS events, 3 loop recorders, and 4 others). Mortality was 6.9% (89 GTP), including 7.3% with AF-RVR (n=6) and 13.3% with New-AF (n=4). Cardiac complications occurred in 62% of AF-RVR patients (53), including dysrhythmias, MI, stroke, CHF, and cardiac arrest.

Conclusion: AF-RVR in GTP have higher risk and poorer outcomes. Key contributors include CHF, cardiomegaly, transfusion need, CKD, major surgery, blood loss, smoking, and IDDM. GTP with these factors benefit from early EKGs and ≥ 72 hours of telemetry.

B111

Metabolic Syndrome and Physical Function Impairment Among Mexican American Older Adults: Sex Differences

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Background: Metabolic syndrome (MetS) is a growing global public health concern, with inflammation and hormonal imbalances contributing to decreased muscle mass and mobility limitations. However, the impact of MetS on physical performance among Hispanic older adults is not fully understood. This study examined sex differences in the relationship between MetS and physical function impairment among Mexican American older adults with moderate to high physical function at baseline over a 23-year follow-up period.

Methods: Participants (N = 1574) aged 65 years and older from the Hispanic Established Population for the Epidemiologic Study of the Elderly were followed from 1993/94 to 2016. Measures included MetS criteria (predictor); physical function impairment (outcome), defined as scoring < 7 on the Short Physical Performance Battery (balance, timed walk, 5-repeated chair stand); and socio-demographics and health characteristics as covariates. Generalized Estimating Equation models were used to estimate the odds ratio (OR) and 95% confidence interval (CI) of physical function impairment by sex as a function of MetS over time after controlling for covariates.

Results: Female participants with three MetS criteria had greater odds of physical function impairment (OR = 1.50, 95% CI = 1.07-2.08) over time compared with female participants without MetS after controlling for covariates. Among male participants with three MetS criteria, the relationship with physical function impairment was not statistically significant (OR = 1.32, 95% CI = 0.79-2.21) over time compared with male participants without MetS after controlling for covariates.

Conclusion: Older Mexican American women with MetS had greater odds of physical function impairment over time. Understanding the relationship between MetS and physical function among older women, who are particularly vulnerable to comorbidities such as cardiovascular disease and osteoporosis, can help inform targeted public health strategies and guide lifestyle interventions to mitigate the onset of disability and premature death in these populations.

B112 Student Presentation, Encore Presentation

Polypharmacy and Medication Self-Efficacy in Older Emergency Department Patients

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Background: Over 50% of older adults in the US take ≥ 5 medications, with prevalence reaching 76.8% in the emergency department (ED) setting. However, little is known about their medication self-efficacy (the ability to understand and follow medication regimens), which may influence adherence and adverse drug events when new prescriptions are added during ED visits. Our objective was to determine whether polypharmacy and high-risk medications are associated with self-efficacy.

Methods: We performed a logistic regression analysis using 5-site multicenter ED survey data linked to electronic health records from patients aged ≥ 65 years with baseline ED visits during 2019-2021. The predictors were polypharmacy (≥ 5 medications) and high-risk medication use (≥ 1 medication, GEMS-Rx criteria) of

prescriptions taken within 1 year of the ED visit. The outcome was low medication self-efficacy (< 11 points MUSE-taking score) assessed at the ED visit. Covariates included insurance, education, marital status, race/ethnicity, caregiver support, dementia status, and frailty.

Results: Among 921 patients, 249 (27.0%) had polypharmacy and 66 (7.2%) had GEMS-Rx use. Low medication self-efficacy was reported by 76 (37.8%) with polypharmacy and 26 (12.9%) with GEMS-Rx use versus 125 (62.2%) and 40 (5.6%) without. Both polypharmacy (aOR 1.48, 95% CI 1.03-2.12, $p=0.03$) and GEMS-Rx use (aOR 2.36, 95% CI 1.35-4.08, $p=0.002$) were associated with greater adjusted odds of low medication self-efficacy (Table 1). Covariates associated with lower self-efficacy included minority race/ethnicity and greater frailty, while being married was associated with lower odds of low self-efficacy.

Conclusions: These findings suggest that the ED is an important setting to identify older adults who may struggle with medication use.

Table 1. Adjusted odds of low self-efficacy (95% CI)

High-risk medication use (GEMS-Rx model)	2.36 (1.35-4.08)
Polypharmacy (polypharmacy model)	1.48 (1.03-2.12)
Probable dementia	2.03 (0.90-4.42)
Has caregiver	0.66 (0.43-1.01)
Minority race/ethnicity	1.49 (1.05-2.13)
Married	0.67 (0.45-0.97)
Education (years)	0.96 (0.91-1.01)
Medicaid	1.06 (0.71-1.57)
Frailty (Rockwood score)	1.18 (1.05-1.32)

Estimates for polypharmacy and GEMS-Rx are from separate adjusted models. Covariate estimates are from the GEMS-Rx model.

B113 Student Presentation, Encore Presentation

Frailty and the nature of adverse events experienced by Veterans initiating treatment for newly diagnosed multiple myeloma

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Method: Using data from the VA Cancer Registry and Corporate Data Warehouse, we identified all Veterans newly diagnosed with MM from 2010 to 2023 and initially treated with bortezomib, lenalidomide, and dexamethasone (VRd)—a first line regimen. All hospitalization discharge summaries in the year following the date of initiation were extracted; Veterans were followed through one year until death or absence of follow-up in VA for three months, after which they were censored. Using diagnostic codes for each hospitalization and clinical documentation of active medical problems that led to and complicated each hospitalization, a content analysis was performed to measure and classify adverse events (AEs) by the National Cancer Institute's CTCAE (v5) criteria. AEs were further classified by their suspected etiology: cancer-related, treatment-related, noncancer-related or interaction between cancer-noncancer-related factors. Poisson regression models assessed the association of frailty—measured by the validated Veterans Affairs-Frailty Index (VA-FI) ≥ 0.2 —with adverse events, adjusting for age.

Results: From 2010-2023, 1110 Veterans were initiated on VRd. The median age was 68.3 years, IQR 62.3, 72.2, 739 (67.5%) had stage II-III MM, and nearly half (49.5%) were frail. The cohort experienced a total of 2774 hospitalizations and 1,425 AEs in the year after treatment initiation. The most common types AEs were Blood and Lymphatic System Disorders (136), Gastrointestinal Disorders (136), Musculoskeletal and Connective Tissue Disorders (133). Compared to nonfrail Veterans, frail Veterans had higher overall numbers of AEs (835 vs. 590), with a disproportionately higher number influenced by noncancer etiology (noncancer + interaction: 475/835 [56.9%] vs. 247/590 [42.9%][CD1]). Frail Veterans had a higher incidence of AEs (1.59 per 1 person-year) compared to fit Veterans (1.02 per person-year; incident rate ratio [IRR] 1.60, 95% confidence interval [CI] 1.43-1.80). Moreover, frail Veterans had twice the incidence of AEs

influenced by noncancer etiology (0.91 per person-year) compared to fit Veterans (0.43 AEs per person-year; IRR 2.10, 95% CI 1.78-2.49).

Conclusions: Frail Veterans are not only at greater risk of adverse events, but this increased risk is mediated in large part by nononcologic health deficits contributing to their frailty.

B114 Student Presentation

Understanding the Psychological Pain Experiences of Older Surgical Patients: A Qualitative Study

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Background: Perioperative pain management in older adults is complex and offers limited medication options. Further, older adults have high rates of depressive symptoms, which are frequently undertreated. In the context of chronic pain, the biopsychosocial model is widely accepted within clinical pain management. Exploring the biopsychosocial model in the setting of acute perioperative pain can help develop non-pharmacologic pain interventions. The study aims to understand the psychological factors that influence acute pain in older surgical patients.

Methods: We used semi-structured interviews to ask patients about their pain management and psychological contributors to pain at 1-7 days post-surgery. We utilized convenience sampling to recruit patients ≥ 65 years old undergoing major surgery at Memorial Hermann Hospital in the Texas Medical Center. Patients were excluded if their clinical condition did not permit participation. Participant responses were analyzed using abductive thematic analysis, with the biopsychosocial chronic pain model as the data framework.

Results: Participants included 9 individuals (median age = 68; 56% male; 56% Black). The preliminary findings support applying the biopsychosocial chronic pain model to acute postoperative pain (Table 1). Patients reported an interaction of pain and depressive symptoms. Anxiety and stress impacted how patients anticipate future pain. There are key factors unique to acute pain that expand the existing biopsychosocial pain model. Biological manifestations of pain influenced how individuals process pain. The acute nature of the pain was reflected in patients' significant anxiety about their clinical course.

Conclusion: The study shows that elements of the biopsychosocial chronic pain model are supported in the acute setting, and specific themes in acute postoperative pain emerged. Understanding the biopsychosocial factors of pain is essential for developing acute pain care models that integrate patients' psychological needs.

Table 1. Psychological domains of acute perioperative pain.

Domain	Quotes
Depression	"I think the sadness is because I was in pain and my mood has a tendency to affect my recovery." -Patient 5
Anxiety around the Future	"How is it going to be at home, if I'm going to be able to manage [the pain]." -Patient 4
Stress	"My attitude has declined, and I am stressed. When I think about pain, I don't think about recovering as much." -Patient 9
Substance Use	"I just don't want a lot of heavy medication. I've had so many people die from doses of pills." -Patient 3
Pain-specific psychological factors	"The swelling [causes] pain, and I learn a lot about where not to put [my foot]." -Patient 1
	"The feelings are affecting the pain, as it is the pain affecting the feeling." -Patient 2
	"I'm hoping to just not think about the pain." -Patient 7
	"The mood is making my pain worse. I want to get better. But my pain isn't agreeing with my mood." -Patient 8

B115 Student Presentation

Fragility Fractures Prior to Single-Level Cervical Fusion in Osteoporotic Patients are Associated with Worse Postoperative Outcomes

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Background: Fragility fractures can be used to diagnose patients with osteoporosis regardless of DEXA score. While prior studies have shown that osteoporosis can be a predictor of poor surgical outcomes,

there is insufficient data describing the significance of prior fragility fractures defining osteoporotic patients compared to those diagnosed with osteoporosis without a history of fracture. Our study investigates whether prior fragility fracture in osteoporotic patients is associated with increased postoperative complications following single-level cervical fusion.

Methods: The TriNetX database was queried to identify patients aged ≥ 50 years who underwent single-level cervical fusion. Patients were then stratified into two groups: those diagnosed with osteoporosis and a concurrent pathological fracture within 5 years prior to cervical fusion, and those with osteoporosis but without any history of pathological fracture. Patients were then 1:1 propensity-score matched for demographics, the Charlson Comorbidity Index, and other relevant comorbidities. Primary outcomes included 1- and 5-year rates of vertebral compression fracture, mechanical failure, pseudoarthrosis, revision surgery, and mortality. Risk ratios (RR) were calculated within the database platform, and statistical significance was set to $p < 0.05$.

Results: 1,037 patients were analyzed in each cohort after propensity matching. Patients undergoing cervical fusion with a prior fragility fracture had significantly higher 1-year rates of pseudoarthrosis (RR 1.97; $p < 0.0001$) and revision surgery (RR 2.10; $p = 0.0112$), and significantly higher 5-year rates of pseudoarthrosis (RR 1.86; $p < 0.0001$), revision surgery (RR 1.73; $p = 0.017$), and mortality (RR 1.42; $p = 0.0003$) compared to the matched control.

Conclusion: Osteoporotic patients with a fragility fracture within 5 years prior to single-level cervical fusion are at elevated 1-year risk of pseudoarthrosis and revision surgery, and elevated 5-year risk of pseudoarthrosis, revision surgery, and mortality. Therefore, fragility fracture leading to a diagnosis of osteoporosis may be associated with worse cervical fusion outcomes compared to a DEXA-based diagnosis alone. This may help guide preoperative risk stratification in this patient population.

B116 Student Presentation

Evaluation of a Next-Generation Cementless Tibial Baseplate in Patients Undergoing Primary Total Knee Arthroplasty

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Background: With arthritis rates rising in an aging population, the demand for total knee arthroplasty (TKA) continues to grow, prompting constant implant design innovation. In 2021, a next-generation cementless knee implant was introduced, featuring a 3D-printed proximal coating and an ingrowth surface engineered to mimic natural bone porosity for enhanced fixation. This study evaluates the clinical outcomes of this specific cementless TKA design.

Methods: Electronic health records were retrospectively reviewed for all primary TKAs performed by a single surgeon between March 2021 and February 2024. Inclusion required primary TKA for osteoarthritis using this specific cementless design with a minimum of 2-year follow-up. Data collection included patient demographics, intraoperative complications, postoperative medical and surgical complications, and patient-reported outcomes. Descriptive analysis was performed using Microsoft Excel.

Results: A total of 115 patients (125 TKAs) were identified, with 10 patients having undergone bilateral TKA. The cohort included 72 (57.6%) females, an average age of 65 years ± 9.49 , and an average BMI of 30.5 ± 4.88 . 72 (57.6%) surgeries were performed inpatient with an average length of stay of 1.7 ± 1.3 days. No intraoperative

complications were reported. 1 (0.8%) revision occurred at 868 days due to aseptic loosening of a subsided tibial component, which was extracted and revised with a cemented implant. KOOS/KOOS Jr. scores improved from a preoperative average of 45.1 ± 16.4 ($N=103$) to 65.2 ± 14.0 ($N=78$) postoperatively. Medical complications included 1 partial popliteal vein thrombus on POD1 and 1 deep vein thrombosis on POD8, both treated successfully with medication.

Conclusion: 2-year outcomes following cementless TKA with a next-generation tibial baseplate demonstrate excellent implant fixation, minimal complication rates, and marked functional improvement. This may be a great option for patients, including older adults, undergoing primary TKA.

B117 Student Presentation

Disparities in Advance Care Planning Discussions in the Emergency Department

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Background: The Emergency Department (ED) is an opportune setting for advance care planning (ACP) and serious illness conversations. This study aimed to identify whether there were disparities in patients identified for ACP conversations during a quality improvement intervention of ACP documentation in the ED, including in race, ethnicity, language spoken, and underlying end-stage diagnosis.

Methods: This was a retrospective observational single-center study at an academic urban tertiary care center. A quality improvement initiative was implemented in May 2023 to increase ED-based ACP discussions and to standardize documentation. Charts from June 1, 2023 through May 31, 2024 were reviewed to assess demographics, comorbidities, and outcomes, and compared to the baseline ED population during the same time period.

Results: A total of 418 unique ACP discussions were documented using the standardized note. The study population had a mean age of 72.1 years, 53.3% female. Within the study population, 59.8% of patients were White, 23.0% Black, 12.2% Hispanic, 2.4% Asian and Pacific Islander, and 2.4% other. The study population had significantly more White patients ($p<0.001$) and significantly less Hispanic and Black patients ($p<0.001$, $p=0.006$) when compared to the baseline patient population. The study population was 89.5% English speaking, 8.1% Spanish speaking, and 2.4% primarily spoke another language, compared to 84.1%, 13.2%, and 2.7% respectively within the general patient population. There were significantly less Spanish-speaking patients and more English-speaking patients when compared to the baseline patient population. White patients and English-speaking patients were significantly more likely to have ACP documents completed at time of ED visit compared to non-White and non-English speaking patients. Palliative care consults were more likely to occur on patients if there was an underlying hematology/oncology diagnosis ($p<0.001$) and significantly less likely if patients had underlying pulmonary ($p=0.020$) or neurologic diagnoses ($p=0.019$). There were no differences in palliative care consults based on language or race.

Conclusion: These results suggest further opportunities to explore equitable access to ACP conversations and palliative care consults from the ED.

B118 Encore Presentation

Delirium and Dementia-Friendly Comfort Carts to Increase Non-Pharmacologic Care: A Pilot Study

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Background:

Hospital environments can be harmful to older adults and contribute to hospitalization-associated disability. To improve health outcomes, guidelines recommend more emphasis on non-pharmacological care to better address physical, emotional, cognitive, and rehabilitative needs of older adults. We sought to develop and evaluate the use of standardized 'Comfort Carts' containing non-pharmacological resources to enhance patient comfort, increase cognitive and physical stimulation, and help manage responsive behaviours associated with delirium and dementia.

Methods:

A 'Comfort Cart' containing a standardized set of non-pharmacological resources for hospitalized older adults at risk of delirium and responsive behaviours associated with dementia was developed through multidisciplinary stakeholder consultations and a needs assessment survey of clinicians, patients, and hospital volunteers. Volunteers were trained to use the 'Comfort Cart' to facilitate patient interactions and non-pharmacological care to all patients admitted to an orthopedic unit at a tertiary care academic hospital. We conducted daily program audits over a 1-year period and post-implementation surveys to evaluate its effectiveness and acceptability.

Results:

The 'Comfort Cart' program has facilitated over 669 patient visits to date by hospital volunteers, including 50 with patients with dementia or those at high-risk for delirium and/or responsive behaviours. Over 168 hours of patient-volunteer interactions were logged with a mean visit duration per patient of 16.5 (SD 19.5) minutes. More than half of visits (58.1%) improved patients' mood or behaviour. The longer the duration of a visit, the higher the likelihood that it would improve a patient's mood or behaviour. In post-program implementation surveys, 76% of healthcare staff agreed that the 'Comfort Cart' addressed barriers for implementing non-pharmacological care and 80% of volunteers stated that the 'Comfort Cart' helped them have meaningful visits with patients. All patients and caregivers surveyed felt that the program was important to meet the needs of hospitalized older adults, and 91% reported that it positively contributed to the perceived level of compassionate and overall patient care that they received in hospital.

Conclusions:

Standardized 'Comfort Carts' satisfy unmet non-pharmacological needs of older adults and positively impact patient experience in hospital.

B119

Assessing Communication Skills in Perioperative DNR Discussions: An OSCE-Based Evaluation of Anesthesia Trainees and Junior Faculty

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Background:

Historically, many institutions automatically suspend Do Not Resuscitate (DNR) orders during the perioperative period. However, the American Society of Anesthesiologists (ASA) has advocated for "required reconsideration" of DNR orders prior to surgery. Despite these guidelines, perioperative DNR discussions remain inconsistent. One contributing factor may be limited experience among trainees in conducting these conversations.

Methods:

We designed an Objective Structured Clinical Examination (OSCE) to assess final year anesthesia residents and first year anesthesia attendings in perioperative goals of care discussions. The OSCE,

administered from 2019-2025 (excluding 2022), featured a scenario involving a critically-ill intubated ICU patient with a newly discovered advance directive declining resuscitation or artificial ventilation. Participants met with a standardized patient (SP) portraying the patient's daughter to discuss goals of care and perioperative DNR options. Performance was evaluated by the SPs across several communication domains including: information gathering, relationship development, education and counseling, and case specific competencies. Scores for each domain ranged from 1 ("not done") to 3 ("well done").

Results:

Thirty-three participants completed a voluntary OSCE between 2019 and 2025 (excluding 2022). Participants demonstrated strong interpersonal skills: 100% maintained a nonjudgmental tone, 82% used effective non-verbal communication, and 72% acknowledged emotion. However, only 54% consistently used lay terms, and just 32% assessed the SP's understanding. While 71% explained DNR concepts clearly, only 53% effectively described resuscitation procedures in plain language. Less than half (49%) helped make a decision that reflected ethical principles and patient autonomy. Information-gathering skills were varied, with 91% avoiding interruptions but only 63% clarifying understanding throughout the conversation.

Conclusion:

Participants excelled at building rapport and showing empathy. However, improvement can be made in communicating complex medical concepts in accessible language and incorporating ethical reasoning into discussions. These findings highlight the need for enhanced training in perioperative goals of care conversations in the residency curriculum.

B120 Student Presentation

Association of hs-CRP With Physical Performance in HFpEF

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Background: Heart failure with preserved ejection fraction (HFpEF) is highly prevalent geriatric syndrome characterized by impaired physical function, exercise intolerance, and poor quality of life. Systemic inflammation is increasingly recognized as a key biological pathway underlying HFpEF physiology. High-sensitivity C-reactive protein (hsCRP) is a biomarker of systemic inflammation, yet its relationship to physical function and quality of life in HFpEF is poorly defined.

Methods: We analyzed participants enrolled in a prospective single-center HFpEF registry at UT Southwestern who completed laboratory testing, 12-item Kansas City Cardiomyopathy Questionnaire (KCCQ), and 6-minute walk distance (6MWD) assessments. Participants were categorized as having elevated (>3 mg/L) or normal hsCRP. [AJ1] Demographics and clinical characteristics were compared between groups. The associations between hs-CRP category and KCCQ - Overall Summary Score (KCCQ-OSS) and 6MWD were evaluated with linear regression models with adjustment for age, sex, and BMI.

Results: Among 345 participants (median age 71 years [IQR 63–78]; 68% female; 28% Black), BMI was higher among those with elevated hsCRP ($p<0.001$), while age, sex, and other comorbidities were similar between groups. Elevated hsCRP was associated with significantly lower 6MWD in both unadjusted (-46.6m ; $p=0.002$) and adjusted analyses (-40.6m ; $p=0.003$). Similarly, elevated hsCRP was associated with worse KCCQ-OSS in both unadjusted (-8.6 ; $p=0.006$) and adjusted analyses (-6.6 ; $p=0.035$).

Conclusions: Among older adults with HFpEF, elevated hsCRP was associated with worse physical function and poorer patient-reported quality of life. These findings support systemic inflammation as a key biologic contributor to symptomatic and functional impairment in older adults with HFpEF and suggest that hsCRP may help identify individuals at heightened risk for adverse outcomes.

B121 Resident Presentation

The Good and the Bad of Gastrostomy Tubes Among Elderly Hospitalized With Head and Neck Cancer

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Background: Gastrostomy (G-) tubes are widely used in head and neck (H&N) cancer care and frequently encountered among hospitalized older adults. We evaluated the clinical profile, leading admission diagnoses, and major inpatient outcomes among patients with G-tubes compared with those without.

Methods: We analyzed adults aged ≥ 50 years hospitalized with H&N cancer in the 2019–2022 Nationwide Readmissions Database. G-tube presence was defined by ICD-10-PCS or device complication codes. Baseline characteristics were compared using weighted proportions. Multivariable survey-weighted logistic and linear regression estimated associations between G-tube presence and inpatient outcomes, adjusting for age, sex, dementia, chronic lung disease, obesity, solid tumor malignancy, diabetes, hypertension, alcohol use, and drug use disorder.

Results: Among 232,344 weighted H&N cancer hospitalizations, 19.4% had a G-tube. Patients with G-tubes were slightly younger but had a higher burden of comorbidities, including dementia, chronic lung disease, complicated diabetes, hypertension, alcohol use disorder, and drug use. Malnutrition was also substantially more common (24.5% vs 16.6%). The leading admission diagnoses among G-tube patients included sepsis, aspiration pneumonia, acute kidney injury, pneumonia, dehydration, and electrolyte abnormalities. In adjusted analyses, G-tube presence was independently associated with higher odds of in-hospital mortality (aOR 1.17), sepsis (aOR 1.58), aspiration pneumonitis and pneumonia (aOR 1.95), dehydration (aOR 1.28), hyponatremia (aOR 1.45), hypercalcemia (aOR 1.35), nausea/vomiting (aOR 1.94), pain crises (aOR 1.66), and respiratory failure (aOR 1.42). G-tube patients also had greater odds of receiving a palliative care consult (aOR 1.43). Conversely, G-tubes were associated with lower odds of AKI (aOR 0.91) and COVID-19 (aOR 0.90). Length of stay was modestly longer, whereas total hospital charges were lower.

Conclusion: Among hospitalized adults with H&N cancer, G-tube presence identifies a clinically complex group with higher burdens of infection, electrolyte disturbances, respiratory complications, malnutrition, and palliative care involvement. These findings highlight the need for enhanced supportive care, close nutritional monitoring, and early goals-of-care discussions in patients requiring enteral support.

B122 Student Presentation

Promoting Physical Activity to Engage in Life Activities (Proactive)

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Background: Hematopoietic cell transplantation (HCT) is a life-prolonging treatment for patients with hematologic malignancies. Older adults are at an increased risk for poor functional outcomes. Proactive is a physical activity (PA) promotion program, spanning multiple phases from pre-HCT through 6 months post-HCT. This report will focus on feasibility as measured by a questionnaire and adherence to the Proactive components, and qualitative feedback from participants from an ongoing pilot study.

Methods: Participants in the intervention received a tailored home-based PA program supported by two core components- coaching (1 session per phase) and support calls (monthly). Adherence was defined as percentage of participants who attended 1 coaching session per phase and received monthly calls. Acceptability, Appropriateness,

and Feasibility¹ (AAF) were assessed by a questionnaire. Participants rated components from 1-5 on a Likert scale (1-strongly disagree to 5-strongly agree). Participants provided feedback and interviews were analyzed by thematic analysis.

Results: Overall, 109 patients were screened from July 2023 to November 2025. Eighty-one (74%) were eligible; 55 consented (68%) and 26 (47%) received the intervention. The mean age was 67.4 years (SD 4.9). Table 1 displays the components, their functions, mean AAF score, and prevalence adherence during HCT phases. Participants found the program provided awareness about the benefits of PA; coaching sessions were valued by those with impaired function and low motivation, whereas calls were preferred for those who were motivated but needed accountability. Those with prolonged and complex recovery wished to be a part of a group with other survivors and more frequent coaching sessions.

Conclusions: Proactive is perceived as feasible, acceptable, and appropriate for older adults undergoing HCT. There is a need to tailor the frequency and mode of delivery of the core components to fit the needs of participants who may experience prolonged recovery and functional deficits.

References:

Weiner BJ, Lewis CC, Stanick C, et al. Psychometric assessment of three newly developed implementation outcome measures. *Implement Sci.* 2017 Aug 29;12(1):108.

Table 1. Components, their function(s), mean AAF and adherence prevalences during HCT phases.

Components and their function(s)	Mean AAF (SD)	Pre-HCT (n=20) N (%)	Hospitalization (n=22) N (%)	Day 30-100 (n=19) N (%)	Day 101-180 (n=14) N (%)
Coaching Session: action-planning and problem-solving	4.3 (0.7)	16 (80%)	22 (100%)	17 (89.5%)	8 (57.1%)
Phone calls: motivation and social support	4.2 (0.7)	19 (95%)	17 (77.3%)	18 (94.7%)	14 (100%)

B123 Student Presentation

The Incidence and Impact of Post-Operative Delirium among Older Surgical Patients with Large Bowel Obstruction

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Background: While it is established that delirium is prevalent post-operatively and associated with worse outcomes among older patients, the incidence and outcomes in older patients with large bowel obstructions (LBO) are unknown. We evaluated the incidence of post-operative delirium among geriatric patients who received surgery for LBO, and to identify how delirium impacts post-operative outcomes.

Methods: This retrospective cohort study utilized our institution's electronic health record driven geriatric surgical dashboard from 2018-2024. All patients ≥65 years who had a billing code related to LBO (K56) and underwent inpatient colorectal surgery were included. Delirium was measured with 4 A's Test (4AT, Alertness, Abbreviated Mental Test-4, Attention, and Acute Change/Fluctuating Course). Post-operative outcomes were length of stay (LOS), measured from date of surgery to hospital discharge, and discharge disposition, characterized as home vs. non-home discharges. Descriptive statistics were used to describe and estimate the incidence of post-operative delirium. Multivariate regression models determined the impact of post-operative delirium on LOS and discharge disposition.

Results: Overall (N=200), the median age was 74 years (IQR: 69.0, 80.0), 49.5% were male, and 68.5% identified as white. In the study population, 19% had post-operative delirium. The median LOS was 9 days (IQR: 6.0, 16.0) and 57.5% were discharged home.

When adjusting for age, race, and gender, those with delirium had an increased risk of longer LOS (aIRR: 1.76, 95% CI: 1.28, 2.42) and non-home discharge (aOR: 5.75, 95% CI: 2.58, 13.9) compared to those without delirium.

Conclusions: Our study shows that the incidence of post-operative delirium for LBO in older patients is nearly 20%. These findings support delirium prevention and interventions among this population. Next steps include investigating the role of frailty on post-operative delirium as well as the impact on additional post-operative outcomes.

Analysis of Delirium and Associated Outcomes

VARIABLES (N=200)	NO DELIRIUM (N=162)	DELIRIUM (N=38)	P-VALUE
Race (%)			
White	117 (72.2)	29 (52.6)	
Non-White	45 (27.8)	18 (47.4)	0.032
Gender (%)			
Male	73 (45.1)	26 (68.4)	
Female	89 (54.9)	12 (31.6)	0.016
Age (median (IQR))	74.00 (69.00, 80.00)	74.00 (69.00, 81.00)	0.986
Length of Stay (median (IQR))	8.00 (6.00, 13.50)	15.50 (11.25, 25.75)	<0.001
Disposition (%)			
Expired	15 (9.3)	3 (7.9)	
Home	106 (65.4)	9 (23.7)	
Hospice	4 (2.5)	3 (7.9)	
Other	0 (0.0)	1 (2.6)	
Skilled Nursing Facility/Subacute Rehabilitation	37 (22.8)	22 (57.9)	<0.001

B124 Resident Presentation

Frailty and Home Day Loss After Surgery for Patients with Non-metastatic Pancreatic Cancer

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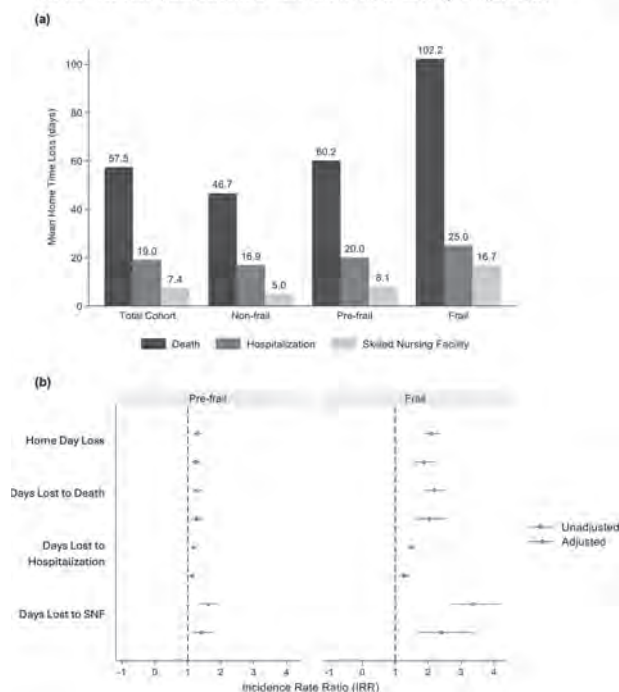
Background: Frailty predicts post-operative complications and functional decline for older adults after major surgery. Its association with home day loss in the year after curative-intent surgery for non-metastatic pancreatic ductal adenocarcinoma (PDAC) is unknown.

Methods: We performed a retrospective cohort analysis using SEER-Medicare data (2013-2022) of patients ≥66-years-old undergoing curative-intent surgery for non-metastatic PDAC. Frailty was categorized as non-frail, pre-frail, or frail using the Claims-based Frailty Index. We calculated home day loss as total hospital days, skilled nursing facility days, and days lost due to death in the year after surgery. We used negative binomial regression to evaluate the association between frailty and home day loss.

Results: Among 4,553 patients (median age 74, 51.8% female, 78.7% White), 2,019 were non-frail (44.3%), 2,180 were pre-frail (47.9%), and 354 were frail (7.8%). Mean home day loss was 83.8 days (Figure 1a). Compared to non-frail patients, pre-frail and frail patients had significantly higher home day loss [pre-frail aIRR = 1.23, 95% CI = (1.10–1.48); frail aIRR = 1.86, 95% CI = (1.57–2.22)] (Figure 1b).

Conclusion: Higher frailty is strongly associated with increased home day loss in the year after curative-intent surgery. This highlights that even modest frailty can have meaningful implications for post-operative recovery and functional independence.

Figure 1: Home day loss, days lost to death, days lost to hospitalization, and days lost to skilled nursing facility stay in the year after curative-intent pancreatic resection for patients with non-metastatic pancreatic ductal adenocarcinoma, stratified by frailty category



B125 Student Presentation, Encore Presentation Ten Year Survivorship and Predictors of Failure After Reverse Shoulder Arthroplasty in Older Adults

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Background

Reverse total shoulder arthroplasty is increasingly used for complex shoulder pathology in older adults, however long-term survivorship data remains limited. Having an understanding of which patients experience failure after the initial postoperative period is crucial for optimizing outcomes in an aging population. This study evaluated minimum ten year survivorship and identified risk factors for failure in a large national cohort.

Methods

A retrospective cohort study was conducted using the PearlDiver Mariner database to identify adults who underwent reverse total shoulder arthroplasty between 2010 and 2013. Patients without active medical records at ten-year follow up were excluded. Failure was defined as any revision procedure identified through standardized procedural and diagnostic codes. Kaplan Meier analysis estimated year one, year five, and year ten survivorship. Multivariate logistic regression identified independent predictors of failure.

Results

A total of 5269 adults met inclusion criteria. The cohort had a mean age of 68 years and was predominantly female. Overall revision occurred in 273 patients during follow up. Survivorship was 97.8 percent at one year, 95.7 percent at five years, and 95.0 percent at ten years. Median time to revision was 509 days and most failures occurred within two years of the initial procedure. Younger age was associated with higher odds of revision (OR: 0.96, $p < 0.001$). Male sex increased failure risk (OR: 1.58, $p < 0.001$). Prior rotator cuff repair increased failure risk (OR: 1.49, $p = 0.046$) as did a primary diagnosis of glenohumeral osteoarthritis (OR: 1.34, $p = 0.02$). Comorbidity burden, diabetes, tobacco use, region of care, income, and employment status were not associated with failure.

Conclusion

Reverse total shoulder arthroplasty demonstrated exceptional ten-year survivorship in a large national sample of older adults. Most failure occurred early which highlights the need for more enhanced postoperative monitoring of patients during the first two years. Younger age, prior rotator cuff repair, male sex, and glenohumeral osteoarthritis were independent predictors of revision. These findings support individualized risk counseling and may guide postoperative surveillance and expectation in geriatric patients undergoing this procedure.

B126

Explaining rural Veteran and Caregiver satisfaction in virtual specialty geriatrics care service

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Background

The Veteran Affairs Tele-Geriatrics and Geriatric Mental Health (tele-GGMH) service has demonstrated high satisfaction among Veterans' caregivers. A possible mechanism of patient satisfaction is a working alliance (WA), which is the interpersonal bond and alignment in treatment goals and tasks (Horvath, 1989). A strong WA could help explain the satisfaction with the tele-GGMH service, particularly given the complexity of care for older Veterans with degenerative cognitive and co-occurring disorders and rural isolation. The qualitative evaluation examined interviews with Veteran and caregiver recipients of tele-GGMH care on their experience to identify a possible mechanism of satisfaction.

Methods

Veterans and caregivers from 3 regions were interviewed. A rapid qualitative approach identified themes related to experience and satisfaction. The theme of WA was derived inductively during this analysis prompting a second thematic analysis of the data for codes and categories related to WA.

Results

Twelve Veterans and 20 caregivers ($n = 32$) were interviewed about their experiences with tele-GGMH services. Cognitive concerns like forgetfulness, amotivation, and anger outbursts were common presenting concerns. Interventions delivered included medication changes, behavioral coaching to caregivers, and referrals (e.g., sleep study, caregiver support program). Participants expressed high satisfaction, which was generally accounted for by the inductive theme of WA helping explain satisfaction. Interpersonal factors (e.g., feeling heard) and instrumental factors (e.g., receiving education, receiving referrals) were highlighted by both patients and caregivers in explaining their satisfaction. Respondents who reported lower satisfaction alluded to misalignment in either interpersonal or instrumental factors.

Conclusions

WA helped explain high satisfaction with the virtual service across different regions and providers. A strong bond likely helped providers tailor services making Veterans and caregivers sampled feel supported. Future work can examine whether WA is associated with treatment success and decreases in distress in telehealth services.

B127 Student Presentation

Lack of Concordance among Physical and Chart-Based Frailty Assessments for Older Lung Transplant Candidates

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Background: As the population ages, frailty is increasingly used to risk-stratify older lung transplant (LT) candidates. Many frailty assessments exist, but whether they identify the same patients as frail is unknown. Understanding overlap may improve risk stratification and guide transplant candidacy.

Methods: Patients ≥ 60 years undergoing LT evaluation (2017-2024) were enrolled in an IRB-approved study. Physical frailty was assessed using the Fried Frailty Phenotype (FFP), a global frailty score, and the Short Physical Performance Battery (SPPB), measuring lower extremity performance. A chart-based measure, the Lekan Frailty Risk Score (FRS), which includes psychosocial and biologic components, was also performed.

Results: Of the 109 patients assessed (median age=68.1, 63.6% male), most had UNOS Group D (restrictive) Lung disease. Frailty was not associated with age, sex, race, or underlying lung disease by any measure. 14 patients (13%) died pre-LT, 75 underwent transplant, and 27% died post-LT within 5-year follow-up. Frailty prevalence was similar among measurements (FFP 34%, SPPB 29%, FRS 38%), but concordance was poor. FFP was weakly correlated with both SPPB (R^2 0.018, $p < 0.001$) and FRS (R^2 0.060, $p = 0.03$), but SPPB and FRS had no significant association. Many patients classified as frail by one metric were not identified by others. Each frailty metric predicted different outcomes: FFP was significantly associated with waitlist mortality ($p = 0.007$), while SPPB was significantly associated with death post-LT ($p = 0.028$), and FRS was correlated with successful transplantation ($p = 0.036$).

Conclusions: Different frailty assessments identify unique subsets of older lung-transplant candidates as frail. Frailty is not uniform in this population, and a multifaceted approach tailored to evaluate older pre-LT patients would improve risk stratification and guide targeted interventions.

B128

Improving Medication Appropriateness in Older Adults with Cancer

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Background: Older adults with cancer have comorbidities requiring medications. Polypharmacy (> 5 medications daily) and potentially inappropriate medications (PIMs) put them at risk for adverse outcomes. Deprescribing, the process of removing medications that could cause harm or no longer provide benefit, can reduce the risk of negative outcomes. This study evaluated a senior adult oncology consultation (SAOC) program that included deprescribing recommendations by a pharmacist to determine the impact on polypharmacy, medication appropriateness and health outcomes (PIM use, falls, hospitalizations, and mortality).

Methods: Electronic medical record data was reviewed to identify those who received a SAOC (baseline) from January 2023

to March 2024 ($N = 149$) and evaluate its impact on health outcomes 6-months post consultation.

Results: The sample was primarily female (60.4%), White (62.4%) with a mean age of 74. Hematologic/blood (42.3%) and breast cancers (20.1%) were the most common primary cancer sites. At baseline, patients took an average of 11 medications, and 20% were taking one PIM. Over 60% ($n = 90$) had a medication review during their baseline consultation by a pharmacist, and 42% received a deprescribing recommendation. Of those who received a deprescribing recommendation, 58% stopped taking the medication and 90% remained off the medication at 6-months. The proportion of older adults who received a deprescribing recommendation and were taking PIMs decreased from 76% to 34% in 6 months. There was no significant change in the number of medications taken per day at baseline vs. 6-month follow-up. Deprescribing did not impact the odds of experiencing health outcomes, including falls, hospitalization and mortality within 6-months of consultation.

Conclusions: SAOCs that included pharmacist-led deprescribing recommendations reduced the use of PIMs among older adults with cancer. However, deprescribing did not significantly affect the odds of falls, hospitalizations, or mortality at 6-months follow-up. Future research to explore these outcomes with longer follow up is needed to determine if there is a long-term impact of deprescribing on medication appropriateness and health outcomes.

B129 Student Presentation

Association Between Anesthesia Care, Frailty, and Complications After Cataract Surgery in Medicare Beneficiaries

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Background: Anesthesia-trained professionals routinely administer sedation for cataract surgery in older adults in the US. To elucidate the potential benefits of anesthesia care on mitigating the risks of cataract surgery, we sought to identify the associations between anesthesia care versus no anesthesia care, frailty, and complications after cataract surgery.

Methods: In a cohort of Medicare beneficiaries from the 20% sample undergoing first-eye cataract surgery in 2017, we identified systemic and ophthalmic complications stratified by frailty (measured by the previously validated Kim Claims-Based Frailty Index) and the receipt of anesthesia care. We created separate hierarchical logistic regression models to examine the association between frailty quartiles, anesthesia care, and systemic as well as ophthalmic complications.

Results: We identified 147,664 patients undergoing cataract surgery in 2017. The mean age was 74.6 years; 59.1% were female, and 89.8% received anesthesia care. Approximately 7.7% of patients experienced any systemic complication within 7 days and 1.1% experienced any ophthalmic complications within 30 days. There was no difference in the risk of experiencing a systemic complication when patients had surgery with anesthesia care (7.73%) vs without anesthesia care (7.59%). However, patients who received anesthesia care were less likely to experience an ophthalmic complication (1.07%) when compared with patients who did not receive anesthesia care (1.64%), regardless of frailty quartile (adjusted OR 0.57, 0.62, 0.69, 0.66 for Q1, Q2, Q3, and Q4, respectively, $p = 0.79$).

Conclusions: Most Medicare beneficiaries undergoing cataract surgery received anesthesia care, and the overall incidence of perioperative complications was low. Anesthesia care appeared to be associated with a large relative reduction in the risk of ophthalmic complications among Medicare beneficiaries undergoing cataract surgery, regardless of frailty quartile, but the absolute risk reduction was relatively modest.

B130

Association between frailty and survival among older adults with rheumatoid arthritis and lung cancer

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Background: Individuals with rheumatoid arthritis (RA) have a higher prevalence of frailty, even at younger ages, compared to the general population¹. Among persons with lung cancer, frailty is associated with decreased survival². However, this association has not yet been assessed among patients with lung cancer and pre-existing RA. The objective of this study was to better characterize the contribution of frailty to survival differences among older adults with RA and lung cancer.

Methods: Using nationwide electronic medical records data from the Veterans Health Administration, we included patients aged ≥ 50 years with a lung cancer diagnosis. RA was defined by ≥ 2 RA ICD-9/10 codes 1–365 days apart prior to cancer diagnosis. The validated Veterans Affairs Frailty Index (VA-FI) was used to characterize patient's frailty status. VA-FI is a validated electronic frailty index developed to measure frailty using administrative claims and electronic health records data in Veterans. Patients were characterized as robust, pre-frail, or frail. Cox proportional hazards regression models were used to assess the association between frailty status and survival, adjusting for demographics, smoking history, rheumatic disease comorbidity index (RDCI), prior cancer history, and tumor stage.

Results: We identified 2,864 patients with pre-existing RA and lung cancer; 77.7% were ≥ 65 years, 94.9% were male, 79.2% were White, 93.1% non-Hispanic. Based on the VA-FI, 34% were categorized as robust, 26% pre-frail, and 39% frail.

Age-adjusted mortality rates per 1,000 person-years were 403.3 for robust, 398.9 for pre-frail, and 410.8 for frail patients. In multivariable analysis, compared with robust persons, pre-frail persons had a mild increased risk of mortality (aHR 1.11; 95% CI: 1.00–1.24), while frail patients had a statistically significant higher risk (aHR 1.27; 95% CI: 1.12–1.43).

Conclusion: Among Veterans with RA and lung cancer, frailty was common and associated with worse survival. These findings highlight the prognostic importance of frailty and suggest it may be routinely assessed to guide risk stratification and clinical decision-making in this population.

B131

Obesity as a predictor of urge incontinence severity, physical function, and fall risk among women over 70

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Background: Urgency urinary incontinence (UUI) is a highly prevalent condition affecting around 40% of women aged ≥ 70 and has been identified as a risk factor for falls. Obesity (BMI ≥ 30 kg/m²) is associated with both greater UUI prevalence and increased fall risk. However, the relationship between obesity, UUI severity, and fall risk in this population remains underexplored.

Methods: Secondary analysis of baseline data from the MoVEonUP study (Mobility and Voiding Exercises in Older Women with Urinary Incontinence), a randomized trial evaluating an exercise and bladder-training intervention to reduce falls in women ≥ 70 with UUI. Baseline clinicodemographic data collected at baseline visits were compared between women with BMI < 30 and ≥ 30 using descriptive statistics. Multivariable linear regression models assessed the relationship of BMI to the Short Physical Performance Battery (SPPB)

and the International Consultation on Incontinence Questionnaire–Short Form (ICIQ-SF). All models were adjusted for age, race, and baseline fall history.

Results: BMI data were available for 222 women (70% of participants). Mean BMI was 28.0 ± 5.8 , and 67 (30.2%) had BMI ≥ 30 . Clinical and demographic characteristics were similar between BMI groups. Women with obesity had higher mean ICIQ-SF scores (12.2 vs 10.7, $p = 0.004$). A higher proportion of women with obesity required > 13.5 seconds to complete the Timed Up and Go test (31% vs 18%, $p = 0.034$). In adjusted models, BMI ≥ 30 was associated with lower SPPB scores (MD: -0.68 ; 95% CI -1.30 to -0.06) and higher ICIQ-SF scores (MD $+1.52$; 95% CI 0.49 to 2.54). Findings were consistent when evaluating BMI as a continuous variable. Each 1 unit increase in BMI was associated with lower SPPB scores (β : -0.09 SPPB points; 95% CI -0.14 to -0.04 ; $p < 0.001$) and higher ICIQ-SF scores (β : $+0.11$ ICIQ-SF points; 95% CI 0.03 to 0.19 ; $p = 0.009$).

Conclusions: Among community-dwelling women ≥ 70 with UUI, obesity is independently associated with greater UUI symptom severity and reduced physical function. This highlights the importance of integrative approaches addressing weight, physical function, and bladder symptoms together to mitigate fall risk and improve overall health outcomes in older women.

B132 Student Presentation

Risk of Deep Vein Thrombosis and Pressure Ulcers Among Older Adults Treated with Suvorexant vs. Zolpidem: A Retrospective Cohort Study

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Background: Insomnia is common among older adults and is frequently managed with hypnotic medications that differ in their effects on arousal and mobility. Zolpidem, a widely used Z-drug, is listed in the American Geriatrics Society Beers Criteria as a medication to avoid in older adults, while suvorexant, a dual orexin receptor antagonist, is offered as an alternative. However, little is known about how these medications differ in their association with immobility-related complications such as deep vein thrombosis (DVT) and pressure ulcer development; therefore, this study compares the risk of these outcomes among adults aged 65 years and older treated with suvorexant versus zolpidem.

Methods: Participants (N=32,436) aged 65 years and older were identified from the TriNetX Research Network. Individuals were included if they had a diagnosis of insomnia and an incident prescription for either suvorexant or zolpidem. Outcomes included incident DVT and incident pressure ulcer. Propensity score matching produced two balanced cohorts. The risk of each outcome was assessed from 30 days after the index prescription through 5 years of follow-up. Risk ratio (RR) and hazard ratio (HR) with 95% confidence interval (CI) were derived from matched risk analyses and Kaplan-Meier survival models.

Results: In the DVT analysis, suvorexant users experienced a lower risk of incident DVT compared to zolpidem users (RR 0.75, 95% CI 0.64–0.88). In the pressure ulcer analysis, suvorexant users similarly demonstrated a reduced risk of pressure ulcer development (RR 0.79, 95% CI 0.68–0.91). Kaplan-Meier survival models showed consistent findings over the follow-up period (DVT HR 0.72, 95% CI 0.61–0.84; pressure ulcer HR 0.76, 95% CI 0.66–0.88), with suvorexant users consistently experiencing fewer events than those receiving zolpidem.

Conclusion: Among older adults with insomnia, suvorexant use was associated with significantly lower risk of DVT and pressure ulcers compared to zolpidem. These findings reinforce the importance of avoiding Z-drugs in older adults and selecting safer hypnotic alternatives when medication is required.

B133 Student Presentation

Timing Matters: Impact of Early Versus Delayed Reversal in Geriatric Trauma Patients on Anticoagulants

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Background: Geriatric trauma patients are at increased risk of hemorrhage-related complications following injury, in part, due to high levels of chronic anticoagulant therapy. Prompt anticoagulant reversal is often recommended in bleeding patients; however, the timing of reversal is a critical yet understudied factor. This study aimed to evaluate whether administering a reversal agent within one hour of emergency department (ED) arrival is associated with reduced transfusion requirements, shorter ICU stays, and improved discharge outcomes.

Methods: We conducted a retrospective cohort study of 84 trauma patients aged 60 years and older admitted to a state-designated level I trauma center between January 2023 and December 2024. All patients were on chronic anticoagulants, including warfarin, heparin, enoxaparin, dabigatran, apixaban, rivaroxaban, or clopidogrel. Patients who received a reversal agent were included and stratified based on time of reversal: those who received reversal within one hour of ED arrival (early) and those who received it after one hour (delayed). Primary outcomes were packed red blood cell (PRBC) transfusions within 48 hours of admission, ICU length of stay (LOS), and discharge disposition (home, SNF/IPR, or hospice/morgue).

Results: Among the 84 patients, 41 (49%) received reversal within one hour. The early group required significantly fewer PRBC units within 48 hours compared to those in the delayed group (1.725 vs 3.125 units; $p = 0.002$). ICU length of stay was lower in the early group (4.35 vs 5.37 days), though the difference was not statistically significant ($p = 0.18$). There was no significant difference in discharge disposition across groups ($p > 0.05$).

Conclusions: In geriatric trauma patients on chronic anticoagulants, reversal within one hour of ED arrival was associated with significantly lower transfusion requirements and a non-significant trend toward shorter ICU stays. These findings suggest that early reversal may play an important role in limiting bleeding-related interventions in older adults. While the study was limited by small sample size, the results provide a meaningful signal that should warrant further investigation.

B134 Student Presentation

Urinary Tract Infections and Delirium in Older Adults: An Umbrella Review of the Association, Diagnostic Challenges, and Clinical Implications

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Urinary tract infections (UTIs) are the most common bacterial infections among older adults and are challenging to diagnose because of atypical presentations and the high prevalence of asymptomatic bacteriuria. Delirium is also common in the elderly and can be triggered by infections, including UTIs, but the strength and nature of this relationship remains unclear. Because of these diagnostic complexities, it is important for providers to understand the relationship between UTIs and delirium in older adults to guide management and reduce unnecessary antibiotic use. This umbrella review aims (1) to synthesize and evaluate existing systematic reviews on UTIs and delirium in adults 65+, and (2) to assess the diagnostic value of typical and atypical UTI symptoms, including delirium. The review followed JBI and PRISMA guidelines. A comprehensive search across PubMed, Web of Science, Embase, Google Scholar, EBSCO, Cochrane, and Prospero (1990–2025) was completed. Two reviewers screened studies in Rayyan, extracted data, and assessed the accuracy of clinical signs using the JBI 11-item checklist. The search yielded 219 articles; after removing duplicates

and screening, six systematic reviews met the inclusion criteria. These reviews varied in setting and in their definitions of UTI and delirium. Three found a strong association, including one with an OR of 2.67 (95% CI 2.12–3.36). Across studies, 26–32% of delirium patients had a UTI, and 30–35% of UTI patients developed delirium. Only one review evaluated diagnostic signs, noting that nocturia, urgency, and abnormal vital signs were less reliable, while dysuria, urinary frequency, cloudy urine, hematuria, and functional decline were more predictive. Overall, this umbrella review highlights the ongoing challenges in diagnosing and managing UTIs and delirium in older adults. Although evidence suggests a connection, causality is unproven due to observational designs, variability, and lack of standardized criteria. These findings emphasize the need for longitudinal research and updated guidelines to improve diagnostic precision and clinical care.

B135

Leakonomics: The Financial Burden of Urinary Incontinence Stratified by Severity

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Background: Women with urinary incontinence face substantial out-of-pocket costs for incontinence supplies. Prior studies show that worsening incontinence severity is associated with higher supply costs, but less is known about which specific supplies drive this burden. Our primary aim was to investigate which supplies drive this financial burden and elucidate variations in supply usage based on urge urinary incontinence (UI) severity.

Methods: We conducted a secondary analysis of baseline data from the MoVEonUP study (Mobility and Voiding Exercises in Older Women with Urinary Incontinence), a randomized controlled trial evaluating a home-based exercise and bladder training intervention for older women with UI. Participants completed the International Consultation on Incontinence Questionnaire (ICIQ) to classify UI severity and The Incontinence Resource Use Questionnaire (IRUQ) to quantify weekly incontinence supply use. Descriptive statistics were calculated and Student's t-test assessed significance.

Results: Of 319 enrolled participants, 299 reported incontinence supply use. Unit costs were derived from nationally averaged, publicly available sources (Table 1). With the exception of blue pads, use of all supply types increased with worsening incontinence severity. Disposable undergarment use ($p = 0.036$) and laundry needs ($p = 0.002$) were significantly higher among those with more severe UI. Bladder control pads, disposable undergarments, and laundry were the major cost drivers, accounting for 83% of supply costs. On average, participants with more severe UI spent 1.5x more per week on incontinence supplies per week than those with moderate UI (Table 1).

Conclusion: Greater urinary incontinence severity is associated with higher use of most incontinence supplies and greater weekly spending. Policies aimed at reducing financial burden for older adults with urinary incontinence should prioritize coverage or subsidies for the supplies that are major cost drivers.

Average Supply Cost By UI Severity

Supply Type Per Week	Unit Price (\$)	Average Costs Total (n=299)	Moderate UI (n=194)	Severe/Very Severe UI (n=105)	p-value
Pantyliners + Maxipads	0.10	0.22 (0.47)	0.19 (0.41)	0.26 (0.56)	0.245
Incontinence + Bladder Control Pads (Poise, Serenity)	0.35	2.47 (3.52)	2.16 (3.05)	3.06 (4.20)	0.032
Disposable Undergarments	1.20	2.65 (7.19)	1.94 (6.53)	3.95 (8.15)	0.002
Toilet Tissue	0.99	1.27 (2.18)	1.19 (2.14)	1.41 (2.25)	0.404
Paper Towel	0.41	0.26 (2.05)	0.13 (0.88)	0.49 (3.24)	0.149
Blue Pads	0.30	0.03 (0.44)	0.09 (0.51)	0.06 (0.28)	0.598
Laundry Loads	2.50	4.14 (3.02)	3.74 (2.77)	4.88 (3.32)	0.002
Total Weekly Costs	—	11.06 (10.88)	9.35 (10.38)	14.24 (11.11)	<0.001

Mean (SD)

B136

Relationship Between Patient-Centered Communication and Exercise Participation Among Older Adults with Diabetes

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Background: Approximately 16.5 million older adults (29%) aged ≥ 65 years live with diabetes (DM) in the US. Effective DM management can be enhanced through patient-centered communication (PCC). The American Diabetes Association recommends that adults with DM engage in at least 150 minutes of moderate-intensity physical activity per week; however, there is limited understanding of the relationship between PCC and physical activity among older adults with DM. The current study aimed to examine the association between PCC and exercise participation among older adults with DM.

Methods: We analyzed 2024 Health Information National Trends Survey (HINTS) data on adults ≥ 65 with DM. The primary outcome was engagement in at least 150 minutes of moderate-intensity exercise per week. PCC was the key independent variable, measured using a validated PCC scale (range: 0–100). Weighted analyses accounted for the complex survey design. Adjusted analysis was conducted using a multivariable logistic regression model to examine the association between PCC and exercise.

Results: Among a weighted sample of 17.5 million older adults with diabetes, only 34% reported engaging in ≥ 150 minutes of moderate exercise weekly. Mean PCC scores were slightly higher among exercisers compared to non-exercisers (82.3 vs. 79.0; $p = 0.06$). In adjusted models, higher PCC was significantly associated with greater odds of exercise (OR = 1.02 per unit increase; 95% CI 1.00–1.04). Male gender was negatively associated with exercise (OR 0.50, 95% CI 0.27–0.93), while high household income was positively associated (OR 3.51, 95% CI: 1.39–8.87). Poor perceived health was strongly associated with lower exercise participation (OR 0.26, 95% CI 0.13–0.51).

Conclusion: Patient-centered communication is an independent predictor of exercise among older adults with diabetes. Income and perceived health also play critical roles in exercise engagement. Future studies should explore causal pathways linking PCC to physical activity and examine interventions that enhance PCC to promote exercise among older adults with diabetes. Clinicians should prioritize patient-centered communication during encounters, as fostering trust and shared decision-making may encourage physical activity. Tailored counseling that considers socioeconomic and health status could further improve exercise adherence.

B137

Barriers to Post-Acute Care for Older Adults with Substance Use Disorders

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Background:

Substance use disorder (SUD) is increasingly prevalent among older adults, yet many post-acute and long-term care facilities lack policies to manage complex SUD care. This study examines barriers to SNF/SAR placement for hospitalized adults with SUD and describes the clinical characteristics of this population.

Methods:

This retrospective review analyzed a de-identified dataset of 16,467 encounters representing 9,130 patients hospitalized between April 2023 and September 2025. Descriptive statistics summarized demographics, hospitalization details, and disposition outcomes for the full cohort and stratified by age (<65 vs $65+$). Information on substance use-related admission criteria and MOUD policies was compiled from post-acute care facilities across the Chicagoland area.

Results:

Of the 9,130 patients, 31.5% were aged ≥ 65 . Older adults had higher comorbidity (Charlson 6.3 vs 4.0) and were more likely to require ICU care (17.7% vs 15.4%). The cohort was 58.7% white and 24.0% Black, with a greater proportion of white individuals in the older group (65.3% vs 55.2%). Opioid use occurred during 15.5% of encounters overall and 11.2% of older adult admissions. Withdrawal scales were rarely included on admission orders (1.4%). Methadone was less likely to be initiated or continued for older adults (6.9% vs 12.8%). Buprenorphine was prescribed at discharge for approximately 4% of all patients. Most patients were discharged home (83.1%), though older adults were more likely to require SNF/SAR placement (10.1% vs 3.2%). Facility-level analysis showed substantial variability and restrictiveness in SNF/SAR acceptance criteria. Many sites reported automatic or conditional denials based on recent drug use, with abstinence windows ranging from 30 days to one year. Recent IVDU with long-term IV antibiotic needs was the most common reason for denial. Methadone acceptance was highly limited and often restricted unless prescribed for pain, while buprenorphine acceptance was more common but frequently case-by-case.

Conclusions:

Older adults with SUD represent a clinically complex, high-risk population with increased need for skilled post-acute care, yet access is limited, particularly for those with OUD. Future work will further characterize facility-level challenges to inform evidence-based guidelines for managing SUD in older adults in post-acute settings.

B138

Frailty Risk Stratification and Interventions in the Geriatric Surgical Population: A Literature Review

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Background: Frailty is a strong predictor of adverse surgical outcomes among geriatric patients. We do not have a comprehensive understanding of how the different frailty measures are used to risk stratify these patients for length of stay, costs, and discharge to places other than home. Furthermore, there is insufficient evidence on interventions that target frailty in attempts to mitigate deleterious outcomes. We are conducting literature search to learn more about the current state of frailty risk stratification and interventions for geriatric patients, we conducted a literature review.

Methods: We conducted a comprehensive literature search following PRISMA guidelines, abstracts from PUBMED, EMBASE and Web of Science, were systematically screened for literature available on utilization of frailty tools to improve surgical outcomes of older adults. We included studies using explicit frailty tool in patients age 60 years or more.

RESULTS: 2087 articles were found, 576 duplicates were removed, 1511 were screened for title and abstract relevancy. 171 abstracts were considered relevant by 2 reviewers, 16 removed after full text review. Themes drawn from 26 are included in this abstract, 129 more articles are under review. Our preliminary result from this ongoing review suggests that most of the studies are observational, indicating favorable outcomes with the use of multidisciplinary approach, undergoing prehabilitation prior to surgery. Some studies used frailty tools to stratify patients, or they used it screen for post-operative delirium. Others suggest surgery itself as an intervention to improve frail status.

Conclusion: There is an outburst of frailty studies in the recent past, while majority of these studies are observational, confirming an association of frailty with poor surgical outcomes in older adults, there are handful of studies where frailty is the target to stratify risk or to intervene. In this review, we observed several different pathways

to utilize frailty tools to impact surgical outcomes in frail patients. It ranges from applying different surgical techniques, or multidisciplinary team approach, creating unique order sets for frail patients, or using prehabilitation programs, all show promising results.

B139

Minding the GAP: Specialized Cognitive Assessments Drives Higher 4Ms Implementation Fidelity in Geriatrics vs High-Volume Primary Care has Room to Improve

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Background: The 4Ms, Mentation, Mobility, Medications, What Matters Most is an evidence-based framework used to drive age-friendly care to improve health outcomes for older adults. Geriatric and Palliative Medicine (GAP) practices may be more likely to adopt the full 4Ms compared to Internal Medicine (IM) and Family Medicine (FM) who may be less familiar with the framework. The objective was to evaluate the incorporation and fidelity of the 4Ms framework in IM/FM primary care compared to GAP ambulatory practices and assess gaps in screening.

Methods: Retrospective review of ambulatory data from 1/1/25-9/1/25; pulled from 16 IM/FM practices and 3 dedicated GAP practices within a large integrated health system. Data for all adults ≥ 65 years is aggregated into 4Ms and age-friendly dashboards. Evidence-based measures for each M incorporated into the ambulatory EMR as follows: Mentation: PHQ2/9; Mini-Cog; MMSE; MOCA or SLUMS; Mobility: Timed Get Up and Go (TUG); Medication: reconciliation for high-risk meds template; What Matters Most: Goals of Care (GOC) note template. Comparisons made using chi-square test.

Results: The examination period included 29,774 visits to IM/FM and 3771 to GAP. The rate of screening all 4Ms for IM/FM was 0.2% vs. 6.9% by GAP ($p < 0.0001$). Mentation included two components, while IM/FM at 89.5% outperformed GAP at 74.3% for PHQ screening ($p < 0.01$), cognitive assessments of eligible visits were over 100-fold less for IM/FM at 0.2% than GAP which performed cognitive assessments at 23.4% ($p < 0.01$). Mobility screening (TUG) assessed by IM/FM was 18.5% by IM/FM vs 39.7% by GAP ($p < 0.01$). Medication review for presence of high-risk medications was assessed at 29.8% by IM/FM vs 44.5% by GAP ($p < 0.01$). What Matters Most documentation by IM/FM was 29.8% vs 45.2% by GAP ($p < 0.01$).

Conclusions: Adherence to screening for the full 4Ms framework was significantly greater by GAP than other primary providers. Although the GAP providers performed each M more consistently, overall compliance remains low. Given the limitations of GAP providers accessibility, it is imperative for IM/FM primary care to focus on the implementation of the 4M framework to assess the complex needs of older adults and address gaps in care. Additional interventions are needed to increase clinician engagement and to optimize age-friendly care for a greater number of older adults.

B140 Student Presentation

Comparative Outcomes of Suburethral Sling Removal for Pain After Mid-Urethral Sling in Women Above and Below 65

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Background

Mid-urethral slings (MUS) are widely used for stress urinary incontinence management, yet some women develop chronic pain requiring removal. Outcomes after sub urethral sling removal (SSR) may differ in geriatric women due to age-related changes in pain perception, tissue healing, and recovery. This study compares post-operative pain, urinary symptoms, and quality-of-life outcomes in women < 65 versus ≥ 65 years.

Methods

After IRB approval, we retrospectively reviewed charts of symptomatic, non-neurogenic women who underwent SSR alone after MUS

placement, with ≥ 6 months of follow-up after SSR. Demographics, original MUS operative note, presenting symptoms, pre-SSR evaluation, perioperative complications, and post-SSR outcomes using validated questionnaires (UDI-6, QoL) at last follow-up were abstracted. For patients not seen within the past 2 years, standardized phone interviews were performed by a neutral investigator. Data were stratified by age (< 65 vs. ≥ 65 years) for comparative analysis.

Results

The most common indication for SSR in both age groups (< 65 vs. ≥ 65) was dyspareunia and pain. Persistent or new pelvic pain was more frequent in women < 65 (35% vs. 14%, $p = 0.0005$), as was pain consistent with the original indication (22.7% vs. 4.4%, $p = 0.0011$) and follow-up care for pelvic pain (12.7% vs. 3.8%, $p = 0.029$) (see Table 1). Median time from MUS placement to removal was shorter in women < 65 (5 years) than ≥ 65 (6.3 years, $p < 0.0001$). Quality-of-life scores (0–10/worse) were higher in women < 65 (median 5) than ≥ 65 (median 3, $p = 0.0034$). UDI-6 sub scores showed more bladder emptying difficulty (median 1 vs. 0, $p = 0.03$) and higher pain (median 1 vs. 0, $p = 0.018$) in younger women.

Conclusion

Overall, younger patients reported greater post-SSR pain/dyspareunia but also higher perceived quality-of-life gains, whereas older patients experienced fewer pain symptoms but lower functional improvement. These age-related factors play a key role in SSR outcomes and should inform future counselling before SSR.

Standardized phone interview and questionnaire results at last follow-up after SSR by age group

	Age < 65 (n=401)	Age ≥ 65 (n=239)	P<sup>open>
Standardized phone interview	(n=157)	(n=80)	
Persistent/new pelvic pain	55 (35.0%)	11 (13.8%)	0.0005
Pain with intercourse	71 (49.0%)	10 (13.5%)	<0.0001
Seen a provider for pelvic pain	19 (12.7%)	3 (3.8%)	0.029
Pain same as original indication	25 (22.7%)	3 (4.4%)	0.0011

B141 Resident Presentation

GLP-1 RAs vs Metformin for Dementia Risk in Older Diabetics With Delirium

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Background:

Delirium in older adults is strongly associated with and may predate dementia. GLP-1 receptor agonists (GLP-1 RAs) may offer neuroprotective effects, but their role in reducing dementia risk in older patients with type 2 diabetes mellitus (T2DM) and prior delirium is unclear. This study compares GLP-1 RAs versus metformin for dementia prevention in this high-risk population using a large healthcare database.

Methods:

We conducted a retrospective cohort study (2005–2025) using the TriNetX Global Federated Research Network. Adults aged ≥ 65 years with T2DM and delirium who received GLP-1 RAs (exposure) or metformin (control) were included. Propensity score matching balanced groups by demographics, medications, diagnostics, and comorbidities. The primary outcome was incident dementia. Time-to-event analyses used Kaplan–Meier curves and Cox proportional hazards models; odds ratios (ORs) were also estimated. Subgroup analyses were performed by age (65–75 and > 75 years), sex, race, and ethnicity, with sensitivity analyses including additional covariates.

Results/Discussion:

Among 29,520 GLP-1 RA users and 29,520 matched metformin users (mean age 74; 52% female), GLP-1 RA therapy was associated with significantly lower dementia risk (AHR 0.754, 95% CI 0.715–0.794; OR 0.586, 95% CI 0.555–0.620; both $p < 0.001$). Benefit was greater in those aged 65–75 years (AHR 0.679; OR 0.509) than in those

>75 years (AHR 0.836; OR 0.703), suggesting earlier intervention may yield stronger neuroprotection. GLP-1 RAs showed consistent dementia-risk reduction, especially for Alzheimer's and vascular dementia. Variability in frontotemporal and Lewy body dementia outcomes may reflect differing pathophysiology and small sample sizes.

Conclusion:

In older adults with T2DM and delirium, GLP-1 RA therapy is associated with reduced dementia risk compared with metformin, with the strongest effects in Alzheimer's and vascular dementia. Earlier initiation (age 65–75) may confer greater benefit. Prospective trials are needed to confirm these findings and clarify subtype-specific effects.

B142

Ageist Language in Urology Research: A Text Analysis of “Elderly”

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Background: Ageist language in published research amplifies negative stereotypes and implicitly influences clinician recommendations. The American Medical Association (AMA) and the Journal of the American Geriatrics Society published age-inclusive language guidelines initially in 1998 and in 2017, respectively. Urologists treat aging-related conditions, and it is unknown how the guidelines have influenced language in urology journals. Our objective was to identify and track the use of ageist terms in urology journals over time, focusing on the term “elderly” which was flagged as ageist in both guidelines.

Methods: We conducted a text analysis of 3 urology journals (Journal of Urology, Urology, and European Urology) from 1983–2025. Python was used to identify manuscripts containing “elderly” in either the title or abstract. R was used to evaluate the frequency of “elderly” manuscripts by year, to calculate 5-year moving averages, and to produce data visualizations that included timing of release of guidelines.

Results: Out of 58,245 manuscripts, we identified 599 containing “elderly” (1.03%) in the title or abstract. Following publication of the 1998 AMA guidelines, the usage rate of “elderly” leveled off, but it then fell after the release of the JAGS guidelines in 2017 (Figure 1).

Conclusions: In this text analysis of titles and abstracts from 3 urology journals, we found variation but not a consistent direction in the use of “elderly” following publication of guidelines. Our findings suggest that changes in the guidelines had a less than expected effect on use of “elderly” in urology journals. Urology journals should promote compliance with age-inclusive language guidelines to prevent downstream ageism in clinical care.



B143 Student Presentation

Electronic Health Record–Based Detection of Bleeding in Older Adults: Enhancing ICD-10-CM Algorithms with Chief Complaint Data

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Background

Older adults are disproportionately affected by bleeding due to age-related physiological changes, higher comorbidity burden, and frequent antithrombotic use. Current methods for detecting bleeding in the emergency setting primarily rely on diagnostic codes, which may lack optimal sensitivity. We assessed the diagnostic accuracy of using chief complaint (CC) data, combined with an established diagnostic-code-based algorithm, to identify bleeding events.

Methods

We applied our algorithm to classify probable (i.e., bleeding-related CC or International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] identified) and non-probable bleeding encounters for patients aged ≥65 years at six southeastern emergency departments (EDs) between Nov 2024 and July 2025, 3 days after index visit. The algorithm included 213 CCs in addition to 505 ICD-10-CM diagnostic codes previously described as consistent with bleeding. Structured chart review served as the gold standard to confirm accuracy of bleeding event. For confirmed bleeds, reviewers recorded location, severity, and antithrombotic use. Primary outcomes were positive and negative predictive values (PPV, NPV).

Results

We reviewed 3,560 probable and 400 non-probable encounters (mean age 76.6 ±8; 72% non-Hispanic white subjects). The most common CCs for probable bleeding were hematuria (11%), motor vehicle crash (11%), rectal bleeding (10%), epistaxis (7%), and trauma (5%). Bleeding was confirmed in 2,485 probable encounters (PPV 70%; 95% CI 69–72). Among non-probable encounters, the most common CC was fall (13%) with an NPV of 57%. Thirty-six bleeds were observed among non-probable encounters, yielding an overall NPV of 91% (88–93). False negatives were 58% mild, 33% moderate, and 8% severe.

Conclusion

Using CC and ICD-10-CM data can effectively rule out bleeding events in older adults within 3 days of an ED encounter, though refinements are needed to improve rule-in accuracy.

B144

Chronic Kidney Disease Does Not Increase Stroke Risk in Elderly Patients with Atrial Fibrillation

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Background:

Chronic kidney disease (CKD) is associated with a higher risk of ischemic stroke in patients with atrial fibrillation (AF). However, the incidence of CKD increases with aging. Consequently, the observed association between CKD and elevated stroke risk may be further influenced by older age, which in turn leads to a higher stroke risk. To clarify this relationship, our study specifically examines this issue in elderly patients with AF.

Methods:

We studied whether presence of CKD was associated with a higher risk of incident stroke in a hospital-based cohort of 13068

elderly AF patients (≥ 80 year-old) and 16273 younger AF patients (< 80 year-old) from January 2010 to December 2021 for comparison. The primary outcome was hospitalization for ischemic stroke.

Results:

Over a mean follow-up of 4.07 ± 3.55 years, 7636 (26.0%) patients developed ischemic strokes. Elderly patients had a higher stroke rate compared to younger patients. In younger patients, AF patients with CKD had a higher stroke rate compared to those without CKD. However, in elderly patients, those with CKD did not have a higher stroke rate compared to those without CKD. On multivariable analysis adjusting for CHA2DS2-VASc score, patients with CKD had a 51% increase of stroke risk compared to without CKD in the younger group (hazard ratio [HR] 1.51, 95% confidence interval [CI] 1.29-1.77, $P < 0.001$), but not in the elderly group (hazard ratio [HR] 1.06, 95% CI 0.92-1.23, $P = 0.425$).

Conclusions:

CKD independently predicts higher ischemic stroke rates in younger AF patients but not in elderly AF patients. Advanced age, in itself, may override the impact of CKD in AF stroke risk assessment.

B145

Evaluating Home Safety Assessments for Older Adults Enrolled in GUIDE Program

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Background: A goal for many persons living with dementia (PLWD) and their caregivers is to age at home. Home safety assessments (HSAs) aim to improve the quality of life for PLWD. HSAs are on-site visits by a health care provider to address domains such as falls, home hazards, and emergency preparedness. Our GUIDE program enrolled 184 patients during the first year of CMS's Guiding an Improved Dementia Experience (GUIDE) program. We report findings from HSAs conducted as part of initial GUIDE assessments.

Methods: HSAs were conducted by physicians or advanced practice providers within 60 days of the initial GUIDE evaluation using a 40-item standard checklist. Additional measures included demographics and clinical parameters among patients who completed an HSA versus those who did not. Data were analyzed using t-tests and Mann-Whitney U where appropriate.

Results: Among the 184 patients offered an HSA, 73% completed it. Of those who completed an HSA, 62% were female, with a mean age of 82.8 years. CMS complexity level was 35.9% low, 56.5% moderate, and 7.6% high. Average age, FAST score, Zarit Burden Interview (ZBI) score, PROMIS Global Health score, and complexity level were similar between those who completed and did not complete an HSA. The average number of actionable findings identified during HSAs was 3.62 (range 0-19). The top items requiring action were: completed MOLST not posted (59.6%), no access ramp (47.6%), no emergency contact list at bedside phone (42.2%), no locks on 'off limits' cabinets (40.1%), not restricting access to stove controls (39.6%), and lack of a fire extinguisher (39.2%). Further analysis showed that the number of actionable items was not significantly associated with FAST score, ZBI, or Global Health scores.

Conclusions: HSA identified multiple items requiring attention. HSAs offer an opportunity to optimize recommended modifications tailored to the unique needs and home environments of PLWD to help them age in place. Many commonly identified items may be easily addressed to enhance safety and reduce the risk of falls and other adverse events. Future work will include longitudinal follow-up to evaluate how these interventions affect quality of life and health outcomes.

B146

The Effects of an Alpha-glucosidase Inhibitor on the Number and Magnitude of Postprandial Hypotensive Events in Older Adults

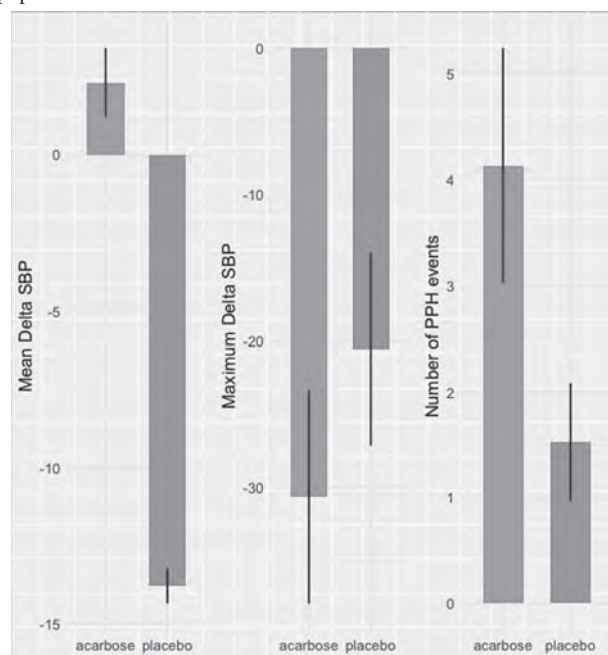
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BACKGROUND: Postprandial hypotension (PPH) is defined as a drop in systolic blood pressure (SBP) of at least 20 mm Hg following a meal. Acarbose, an alpha-glucosidase inhibitor, has been proposed as a possible treatment based on studies involving older adults with diabetes. Its effectiveness in the broader older adult population is uncertain. This study used a randomized, placebo-controlled design to assess the impact of acarbose on postprandial SBP changes in older adults recruited from geriatric medicine clinics.

METHODS: Forty-three older adults (23 women, 20 men; age ≥ 65 years, mean 77.1 ± 0.9 years) were recruited from academic geriatric outpatient clinics. Participants received either 50 mg of acarbose or placebo orally before a standardized meal test.

RESULTS: The mean postprandial SBP decline was significantly smaller in the acarbose group (standardized $\beta = 0.724 \pm 0.286$, $p = 0.017$). However, this group experienced a greater number of PPH events (standardized $\beta = 0.593 \pm 0.279$, $p = 0.040$).

CONCLUSION: While acarbose lessened the average fall in SBP during the meal test, it did not decrease the frequency of PPH events among community-dwelling older adults. These findings suggest that additional research is required before acarbose can be recommended for PPH management in the general older adult population.



Postprandial Systolic Blood Pressure (SBP) Response

B147

Interplay between cognition, physical function, urinary incontinence, and falls

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BACKGROUND

Falls are common in older women and may reflect interacting deficits in cognition, mobility, and continence. Women with urinary incontinence (UI) often experience concurrent impairments, yet their combined effect on fall risk is unclear. We evaluated independent and joint associations of cognitive function, physical performance, and UI severity with falls in older women with UI.

METHODS

We analyzed baseline data from 319 women (mean age 76.9±5.2) enrolled in the Mobility and Voiding Exercises in Older Women with Urinary Incontinence (MoVEonUP) trial. Cognition was assessed with the Montreal Cognitive Assessment (MoCA) and Trail Making Test A/B. Physical function was measured with the Short Physical Performance Battery (SPPB) and Timed Up and Go (TUG). UI severity was measured using the International Consultation on Incontinence Questionnaire–Short Form (ICIQ-SF). Outcomes included any fall in the past 12 months and fall frequency (0, 1, ≥2). A multidomain impairment score (0-3 impaired domains) assessed cumulative risk.

RESULTS

Falls were reported by 40% of participants (23% 1 fall; 18% ≥2). MoCA scores did not differ between fall groups ($p=0.307$), while TMT-B showed borderline associations ($p=0.051$). Physical function had the strongest association: fallers had lower SPPB scores (median 9 vs 10; $p<0.001$), higher SPPB impairment (18% vs 6%; $p=0.001$), and more TUG impairment (61% vs 45%; $p=0.029$). UI severity did not differ between fallers and non-fallers ($p=0.192$), though severe UI was more common in women with ≥2 falls (50% vs 31%; $p=0.031$). Multidomain impairment showed a graded pattern: women with 2 impaired domains had ~1.6-2.0× higher fall risk, and those with all three impaired had the highest risk (RR 1.8–2.5).

CONCLUSIONS

In older women with UI, physical function was the strongest correlate of falls, with executive dysfunction adding modest risk. While UI severity alone did not differentiate fallers, severe UI was linked to recurrent falls. Multidomain impairment showed a clear dose-response relationship. Future multidisciplinary fall-prevention strategies must incorporate assessments of cognitive function, physical function, and UI.

B148

VA measure of long-term care risk also identifies Veterans with >25% annualized risk of fall injury

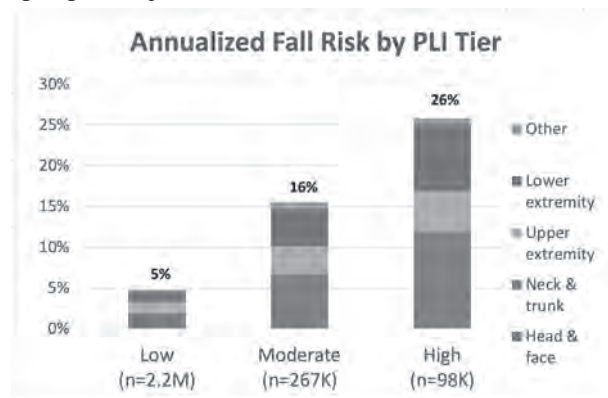
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Background: Fall-related injuries (FRI) are sentinel markers of impending hospitalization, but little is known about their presence prior to long-term institutionalization (LTI). Veterans in the high-risk tier using Predicting Long-term Institutionalization (PLI) high-risk tier Veterans with > 6% 2-year risk of LTI.

Method: In this cross-sectional study of 2.6 million Veterans age 65+, we compared incident FRIs (July to Dec 2019) between high, intermediate, and low-risk PLI tiers. A validated algorithm used ICD-10 codes to identify a spectrum of high to less severe FRIs involving head/face, neck/trunk, and upper and lower extremities treated in either VA inpatient or outpatient settings.

Results (Fig): Veterans in the high PLI risk tier comprised 3.6% of the 2.6 million Veterans vs 10% and 82% of those in the intermediate and low risk tiers. Overall, annualized FRI risk was 6.6%. Those in the high PLI risk tier had 25.8% annualized risk of FRI, compared to 16% and 5% for the intermediate and low risk tiers (OR of 6.1 (95% 5.9-6.2) for high vs low risk; OR of 3.5 for medium vs low risk (95% 3.4-3.5). Among anatomical regions involved in the FRIs, the high PLI risk tier conferred the most risk for head/face FRI (OR for high vs low risk PLI 7.9 (95% 7.5-8.2), med vs low 4.1 (3.9, 4.3), followed by lower extremity FRI (OR high vs low risk PLI 6.9 (95% 6.6, 7.1); med vs low 3.8 (95% 3.7, 4.0).

Discussion: FRIs are potential signals that frail older adults might need more supervision and attention to safe environments. Thus, incorporating information about falls in frailty indices may improve targeting of LTI preventive efforts.



High vs low PLI conferred > 5 x the FRI risk

B149

Dual incontinence, falls and physical function among community-dwelling older women

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Background: Urinary incontinence (UI) is a highly prevalent condition among older women. Older women are also at risk for falls, and UI is associated with increased fall risk. Patients who have fecal incontinence (FI) and UI (termed dual incontinence, DI) have a 2-fold increase in fall risk. This study aims to assess the fall risk and baseline physical function among community-dwelling women with DI versus those with UI alone. We hypothesized that those with DI would have worse physical performance and increased fall risk compared to those with UI alone. **Methods:** This cross-sectional study used baseline data for participants in the Mobility and Voiding Exercises in Older Women with Urinary Incontinence (MoVEonUP) randomized controlled trial. The MoVEonUP trial evaluates the short- and long-term efficacy of a home-based, multicomponent intervention for reducing falls and UI and among community-dwelling women aged ≥70 with UI. Demographic data and fall history were collected at study intake. Participants were categorized as having DI if they reported having FI at study intake. Baseline physical function was assessed using validated questionnaires. Primary outcomes included fall history and baseline physical function among women with DI vs UI alone. **Results:** Of 319 patients with baseline data, 44 (13.8%) had DI. Demographic characteristics were similar between groups. Compared with women with UI alone, those with DI were more likely to use a cane/walker (30% vs 16%, $p=0.04$) and had higher rates of CVD (25% vs 13%, $p=0.04$) and lung disease (25% vs 9% $p=0.003$). A history of a fall in the prior year did not differ significantly between groups (45% vs 39%, $p=0.44$). Participants with DI had significantly higher (worse) Falls Efficacy Scale scores (32.0 vs 27.4, $p=0.002$) indicating greater concern with falling. No differences were observed in overall physical activity.

Conclusions: DI was common among community dwelling older women UI. Those with DI had similar levels of baseline falls and physical function vs those with UI alone, yet higher concern for falling. Findings underscore the importance of screening for DI and addressing fear of falling among older women with DI as part of comprehensive care.

B150

Cognitive Risk and Hearing Decline in Late Life: Evidence from the NHATS Rounds 11-13

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Background

Hearing loss and cognitive impairment frequently co-occur in aging, each contributing to functional decline. Yet, while hearing loss as a dementia risk factor is well studied, the role of baseline cognitive vulnerability in later hearing loss remains unclear.

Methods

Data for this analysis was drawn from Rounds 11-13 of the National Health and Aging Trends Study (NHATS), for a sample of 548 patients aged ≥ 70 years with normal hearing. Incident hearing loss (outcome) was defined as a better-ear pure-tone average >25 dB HL. Baseline cognitive function (exposure) was measured using four validated domains to create a weighted, categorized composite score. Multivariable logistic regression assessed the association between baseline cognitive risk categories and incident hearing loss, adjusting for demographic, lifestyle, and cardiovascular covariates. Analyses were conducted in Python 3.9 with $\alpha=0.05$.

Results

Age was a strong predictor of incident hearing loss. Adults aged 80–90 had higher odds of developing hearing loss (OR 1.83, 95% CI: 0.15 to 1.07; $p = 0.01$), with similarly elevated estimates for those 90+ (OR 2.06, 95% CI: -1.60 to 3.04; $p = 0.54$). Hearing aid use was also associated with greater odds of incident hearing loss (OR = 4.07; $p = 0.05$). Sex and cognitive risk showed directionally consistent but nonsignificant associations. Women had lower odds of incident hearing loss (OR 0.68, 95% CI: -0.85 to 0.08; $p = 0.10$). Baseline cognitive risk demonstrated a graded pattern, with the highest-risk group showing the greatest increase in hearing loss odds (OR 1.91, 95% CI: -0.11 to 1.40; $p = 0.09$). This gradient suggests a plausible link between pre-existing cognitive vulnerability and later auditory decline.

Conclusion

Age emerged as the primary driver of incident hearing loss, with a graded cognitive-risk signal implicating neurocognitive vulnerability in auditory decline. These findings highlight cognitive vulnerability and hearing loss as linked geriatric syndromes shaped by aging biology and support integrating audiologic and cognitive screening into geriatric care for earlier risk detection.

References

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B151

Rational Antipsychotic Selection for Hyperactive Delirium in Older Adults

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Background:

Systematic reviews have not shown superiority of any specific antipsychotic for delirium outcomes, due to which drug selection is often idiosyncratic, based on prescribing preference. We propose a rational, patient-centered framework for antipsychotic selection explicitly focused on multi-receptor effects of these drugs with their associated risk of geriatric syndromes or hazards in older adults.

Methods:

We searched PubMed, Scopus, and Cochrane (through Oct 2025) for frameworks on antipsychotic selection, using terms related to delirium, drug selection, and specific antipsychotics, with and without filters for older adults. We cross-referenced pharmacodynamic data from Stahl's Essential Psychopharmacology and the Prescriber's Guide to construct multi-receptor profiles of commonly used antipsychotics.

Results:

Literature review highlights the importance of multi-receptor actions, particularly for atypical antipsychotics, which derive efficacy via D2 antagonism but also exhibit affinity for H1, 5HT-2, M1, and $\alpha 1$ receptors. Several studies support a pharmacology-based approach to antipsychotic selection though none provide a comprehensive framework for antipsychotic selection in older adults based on risk of geriatric syndromes. In Table 1, we present a "geriatric risk profile" of different antipsychotics based on their multi-receptor effects, drug interactions and drug elimination/half life ($t_{1/2}$), to guide systematic and individualized selection of antipsychotics in older adults with hyperactive delirium. For instance, in a delirious older adult with an anticholinergic syndrome like urinary retention, olanzapine or quetiapine should be avoided due to their higher anticholinergic burden.

Conclusion:

Antipsychotic selection for delirium in older adults remains idiosyncratic. We propose a rational, patient-centered framework reconciling individual risk factors with a comprehensive "geriatric risk profile" based on multi-receptor effects, drug interactions, and pharmacokinetics.

The Risk of Geriatric Syndromes or Complication Related to Antipsychotic Use

Geriatric Syndrome or Hazard	Predominant Mechanism	Haloperidol	Risperidone	Olanzapine	Quetiapine	Aripiprazole
Parkinsonism (EPS)	D2 Receptor blockade	High	High	Moderate	Minimal	Low
Sedation	H1 Receptor blockade	Low	Low	Moderate	High	Low
Orthostasis	$\alpha 1$ Receptor blockade and Autonomic effects	Moderate	Moderate	High	High	Low
Anticholinergic Burden	M1 Receptor blockade	Low	Low	High	High	Low
QTc Prolongation	HERG K+ Channel modulation	High	Moderate	Moderate	Moderate	Low
Seizure	General neuronal excitability	High	Moderate	Moderate	Moderate	Low
Drug-Drug Interactions	CYP450 metabolism	Moderate	Moderate	Moderate	High	High
Reduced Drug Clearance	Hepatic/Renal excretion	$t_{1/2}$ 12 hours	$t_{1/2}$ 20 hours	$t_{1/2}$ 30 hours	$t_{1/2}$ 6 hours	$t_{1/2}$ 75 hours

B152 Student Presentation

Mindfulness in the Midst of Violence: A Paradoxical Predictor of CNA Turnover Intent in Nursing Homes

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Background: Nursing homes (NHs) face a staffing crisis, threatening their ability to meet resident needs. Certified nursing assistants (CNAs), who provide the majority of direct care, have particularly poor retention. Compared to other staff, CNAs face higher levels of resident aggression, an experience strongly associated with intent to leave. Mindfulness reduces depression and burnout among CNAs – factors that are also associated with turnover intentions, suggesting mindfulness may serve as a protective mechanism. However, no studies have yet explored whether mindfulness buffers the impact of workplace violence (WPV) on turnover intention. This study aims to fill this gap. **Method:** Participants ($n = 294$) were predominantly White (83.3%), non-Hispanic (88.3%), and cisgender women (83.3%), with a mean age of 32.15 ($SD = 12.98$). Participants were recruited from NHs across Wyoming and completed a survey assessing factors related to well-being and occupational outcomes. A moderation analysis was conducted to examine whether mindfulness (Mindful Attention Awareness Scale) influenced the relationship between WPV (Workplace Violence Questionnaire) and intent to leave (single item adapted from the Michigan Organizational Assessment

Questionnaire). **Results:** Higher mindfulness was associated with lower intent to leave ($b = -0.33, p = .001$). However, mindfulness also moderated the relationship between WPV and intent to leave ($b = 0.037, p = .02, \Delta R^2 = 0.0165$). Specifically, mindfulness strengthened the relationship between WPV and intent to leave at moderate ($b = .17, p < .001$) and high ($b = .25, p < .001$) levels of mindfulness, such that at higher levels of mindfulness, WPV significantly increased intent to leave. **Conclusion:** These findings suggest that although mindfulness generally reduces intent to leave, it also heightens sensitivity to WPV, making mindful employees more likely to consider leaving harmful environments. Given that mindfulness, outside of the context of WPV, contributes to lower intent to leave, mindfulness interventions may be important for retention. However, given the paradoxical effect in the context of WPV, it may be important to pair mindfulness interventions with organizational strategies to prevent workplace violence in NHs.

B153 Student Presentation

Predictors of Burnout Among CNAs: The Role of Internal Coping Strategies and Workplace Support

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Background: Burnout is recognized as a serious concern among healthcare workers, with certified nursing assistants (CNAs) experiencing some of the highest levels of burnout compared to other healthcare workers. While demographic factors at a facility may predict burnout, it is important to examine whether internal coping strategies and workplace support negatively predict burnout. Studies have focused on either individual coping or workplace support, but not both. To address this gap, a hierarchical regression was used to test whether workplace support predict burnout above and beyond individual coping. **Method:** CNAs from Wyoming nursing homes completed surveys assessing factors related to well-being and occupational outcomes. Participants ($n = 278$) were predominantly White (87.1%), non-Hispanic (88.8%), cisgender women (83.5%), with a mean age of 32.27 ($SD = 13.00$). For this study, we assessed demographics (age, CNA tenure, and length of employment at facility), burnout (ProQOL), problem-focused coping (Brief COPE), mindfulness (Mindful Attention Awareness Scale), workplace support (i.e., supervisor and coworker support; Leiden Quality of Work Questionnaire), and team inclusion (Health Care Team Inclusion Questionnaire). Hierarchical multiple regression was conducted in three steps: (1) demographics, (2) coping and mindfulness, and (3) workplace support. **Results:** The first model was not statistically significant ($p = .073, R^2 = 0.25$). The second model, which added problem-focused coping and mindfulness significantly improved the model ($p < .001, R^2 = .23, \Delta R^2 = .21$). Mindfulness was a strong negative predictor of burnout ($\beta = -.47, p < .001$). The third model, which added supervisor support, coworker support, and team inclusion was also significant ($p < .001, R^2 = .55, \Delta R^2 = .31$). Supervisor support ($\beta = -.34, p < .001$), team inclusion ($\beta = -.25, p < .001$), and mindfulness ($\beta = -.27, p < .001$) were significant negative predictors of burnout in this model. **Conclusion:** Results suggest that supervisor support and team inclusion are significant protective factors against burnout above and beyond internal coping strategies among CNAs. Future research should develop multi-level interventions that strengthen internal coping strategies while also improving supportive workplace environments.

B154 Student Presentation

Prioritization of Older Adults in Global Climate Change Adaptation Plans: A Policy Document Analysis of 205 Countries

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Background

Climate change poses disproportionate health risks to older adults. Prior analyses described the inclusion of older adults in US and Canadian climate plans. Prioritizing older adults in climate plans is essential to ensuring their inclusion in future policy decisions.

Methods

We identified climate plans for all 218 World Bank countries through governmental websites and international databases. 43 older adult-related keywords were searched within each plan and mentions were categorized into 16 adaptation themes, with inter-rater reliability assessed using Cohen's κ . Themes ranged from strengthening health systems (e.g. access to health care) to infrastructure improvements (e.g. transportation, age-friendly communication) to social supports (e.g. mental health programs). Mentions were further classified into general references to older adults or concrete legislative, programmatic, or funding actions.

Results

There were 205 countries (94%) with climate plans. 125 countries (61.0%) included 1-5 themes, 2 (1.0%) included 6-10 themes, 1 (0.5%) included 11 or more themes, and 77 (37.5%) included no themes. The most represented themes were responses to extreme temperatures, involving older adults in decision-making, and disaster preparedness and response. Only 47 (22.9%) countries outlined legislative, programmatic, or funding actions aimed at supporting older adults.

Discussion

Older adults are underprioritized across global climate adaptation plans. Coordinated efforts to strengthen health systems and infrastructure are needed to protect older adults from climate-related risks. Comprehensive global frameworks will be essential to guide these efforts.

B155

Geographical residence modifying emergency department utilization of older adults with frailty

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Background: Living in a rural community is associated with higher emergency department (ED) utilization by older adults, often due to the increased travel distances for healthcare. There is little known about how older adult frailty trajectories relate to ED utilization geographically. We describe the relationship between ED utilization and frailty trajectories for older adults in rural and urban areas.

Methods: Using linked Centers for Medicare and Medicaid Services data with the National Health and Aging Trend Study (NHATS) (2011-2020), we included participants frailty based on data Fried's phenotype ($n=3,771$). Similar to previous NHATS publications, we used Rural Urban Continuum Codes to define rural (non-metropolitan) and urban (metropolitan). In our previous work using latent growth class analysis, we found four analysis frailty

trajectories (improving, stable, mildly and drastically worsening). A marginalized two-part model was used to determine how geographic residence modifies the relationship between trajectory class and ED utilization costs and negative binomial regression was used to estimate the incidence rate ratios (IRR) of ED utilization.

Results: The sample was 62% female with a mean age of 73.9±0.20(SD) years and 20.3% (n=766) living in a rural area. The stable trajectory had the largest percentage of individuals (41.5%), with 8.4% with an improving trajectory, and 38.5% and 11.6% in the mildly and 11.6% drastically worsening trajectories, respectively. Older adults living in urban areas had a higher mean ratio of ED costs [3.06 95%CI (2.04, 4.61)]; however, there was a lower mean ratio of ED costs for the interaction between urbanicity and a mildly worsening trajectory [0.35 (0.20, 0.63)]. Similarly, urban areas were associated with a higher IRR of ED utilization [2.21 95%CI (1.50, 3.24)], but when considering the interaction between urbanicity and a mildly worsening trajectory, this yielded a lower IRR [0.45 (0.27, 0.74)].

Conclusion: Urbanicity appears protective against ED utilization for older adults with worsening frailty trajectories. This work is hypothesis-generating, as understanding the patterns of healthcare utilization for frailty trajectories can inform how the current healthcare system can better support aging older adults in certain geographical areas.

B156 Encore Presentation

The relationship of frailty trajectories and hospitalizations for older adults living in rural versus urban communities

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Background: Older adults (65+ years) in rural areas are at a higher risk of frailty and costly healthcare utilization due to ecological factors, such as inconsistent support for accessing healthcare. We aim to assess the relationship between frailty trajectories and inpatient hospitalizations in rural versus urban communities.

Methods: We included older adults from the National Health and Aging Trend Study (NHATS, 2011-2020) with complete data for Fried's frailty phenotype scoring (n=3,771). Rurality was defined using Rural Urban Continuum codes, provided by NHATS. Previously, latent growth class analysis defined frailty trajectories (improving, stable, mildly and drastically worsening). Using linked Medicare fee-for-service data, negative binomial regression and marginalized two-part model were used to determine how geographic residence modifies the relationship of inpatient hospitalizations and frailty trajectory using incident rate ratios (IRR) and mean ratios, respectively.

Results: The mean age of the sample was 73.9±0.20(SD) years, 62.0% (n=2,419) female, and 20.3% (n=766) living in rural communities. Trajectory membership breakdown was as follows: 8.4% improving, 41.5% stable, 38.5% mildly and 11.6% drastically worsening. Living in an urban community was associated with higher hospitalization costs [mean ratio 1.53 (95%CI 1.12, 2.10)]. When considering the interaction between urban residence and trajectory class, lower hospitalization costs were associated with the mildly [0.52 (0.36, 0.75)] and drastically worsening [0.60 (0.40, 0.91)] trajectories. Within rural communities, we observed a higher IRR associated with the mildly worsening trajectory [1.72 95%CI (1.32, 2.32)]. For urban communities, a higher IRR was observed for the drastically worsening trajectory [1.65 (1.16, 2.33)].

Conclusion: Urban residence modifies the relationship between hospitalization rate and worsening frailty trajectories, appearing to have a protective quality. Within rural and urban communities, worsening frailty trajectories were associated with higher inpatient costs. Future analyses examining predictors of utilization may serve as intervention targets for frailty prevention.

B157

Physician geriatric training and days alive and spent at home among persons with dementia

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Introduction: Geriatric specialty training aims to provide physicians with expertise in addressing the multifaceted needs of persons with dementia through person-centered strategies to avoid unnecessary hospitalizations and delay transitions to long-term care facilities. This study aimed to compare the number of days alive and spent at home (DAH) between persons with dementia cared for by physicians with vs. without geriatric training.

Methods: We identified Medicare beneficiaries aged ≥66 years with dementia in a 20% sample of 2016-2020 Medicare fee-for-service data. We attributed each beneficiary to a physician responsible for the majority of their evaluation and management visits during the calendar year and determined whether the physician was trained in geriatrics. We defined DAH as the number of days alive during the calendar year minus the number of days spent in healthcare facilities (i.e., hospitals, emergency departments, observation units, skilled-nursing facilities, and long-term care nursing homes), for each beneficiary. We then compared DAH between beneficiaries cared for by physicians with vs. without geriatric training, adjusting for patient and physician characteristics. We used an instrumental variable approach with the proportion of physicians with geriatric training within each county as an instrument to account for unmeasured confounding.

Results: Of 1,342,089 patients with dementia, 72,775 (5.4%) were cared for by physicians with geriatric training. Our analysis found that patients cared for by physicians with geriatric training spent more DAH compared to those cared for by physicians without geriatric training (unadjusted mean DAH among physicians without geriatric training, 338.1 days; adjusted difference by instrumental variable analysis, +6.4 days; 95% CI, +2.4 to +10.4; P=0.002). The difference was primarily driven by fewer days in skilled-nursing facilities (-2.2 days; 95% CI, -3.9 to -0.5; P=0.01) and long-term care nursing homes (-2.7 days; 95% CI, -4.9 to -0.4; P=0.02).

Conclusions: Physicians' geriatric training is associated with more DAH among persons with dementia. These findings suggest that specialized geriatrics training may substantially influence clinically meaningful, patient-centered outcomes in dementia care.

B158

Days alive and spent at home and patient-reported outcomes among Medicare beneficiaries with frailty

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BACKGROUND: Older adults identified days at home (DAH)—defined as the number of days alive and out of health care facilities—as one of the outcomes that matter most to them. However, evidence is limited as to whether DAH is associated with patient-reported outcomes, including life satisfaction and well-being, among older adults with frailty, a population at significantly higher risk of healthcare utilization.

METHODS: We analyzed data from the 2010–2018 Health and Retirement Study (HRS), a nationally representative longitudinal survey of older adults, linked to Medicare fee-for-service data. We identified HRS participants with frailty using the Paulson-Lichtenberg Frailty Index. We calculated DAH as the number of days alive during the 365 days prior to an HRS survey date minus days spent in healthcare facilities (i.e., hospitals, emergency departments, observation units, skilled-nursing facilities, and long-term care nursing homes). We then compared the Satisfaction with Life Scale (SWLS; range

1–7, 7 being the best) and the Scales of Psychological Well-Being (SPWB; range 1–6, 6 being the best) across four DAH groups: 365 days (always at home), 358–364 days, 351–358 days, and <351 days, adjusting for participant characteristics.

RESULTS: Our study included 1,116 participants with frailty. The mean DAH among participants was 354.9 days (SD 26.3 days); 43.2% had 365 days of DAH. After adjusting for participant characteristics, we found no evidence that DAH was associated with SWLS or SPWB (Figure).

DISCUSSION: Using a nationally representative survey linked to Medicare data, we found no evidence that DAH was associated with important patient-reported outcomes among older adults with frailty. Understanding the mechanisms underlying this dissociation is important for developing interventions to improve quality of life in this vulnerable population.

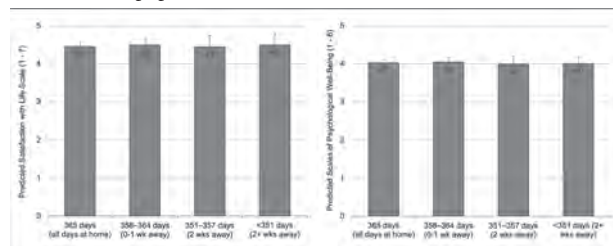


Figure. Association between days spent at home (DAH) and patient-reported outcomes among older adults with frailty

B159

Dementia Plasma Biomarker Testing in Primary Care: Early Findings from the National Dementia Workforce Study

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Background and Objectives: The National Dementia Workforce Study (NDWS) is a nationally representative, multi-year survey of clinicians who care for adults with memory concerns. Drawing on Wave 1 (10/2024-02/2025), we examined the role of plasma biomarker testing in primary care in relation to clinicians' diagnostic confidence, referral patterns, and practice priorities in dementia care.

Methods: We conducted descriptive analyses of clinicians' confidence in diagnosing dementia and Alzheimer's disease, and specialty referral patterns. We then examined associations between diagnostic confidence, specialty referrals, and plasma biomarker testing frequency. Spearman rank-order correlations assessed key associations.

Results: Wave 1 included 4,992 community clinicians nationwide, of whom 3,080 (61.7%) practiced in primary care. One in five primary care clinicians (21.6%) reported low confidence diagnosing dementia in adults ≥ 65 , and 41.2% reported low confidence diagnosing Alzheimer's disease. Neurology was the most common referral path for suspected cognitive impairment (52.9%), followed by Neuropsychology, Psychiatry, and Geriatrics. 7% rarely referred to any of these specialists.

Overall, 15.7% of primary care clinicians reported sometimes or routinely ordering plasma biomarker tests for suspected cognitive impairment. Plasma biomarkers were used less frequently than neuropsychological testing (71.1%) or CT imaging (76.4%), at similar rates to PET scans (18.4%), and more often than CSF (9.7%) or DNA testing (14.8%).

Diagnostic confidence was significantly associated with practice patterns. Lower confidence in diagnosing dementia ($p = -0.06$, $p < 0.01$) and Alzheimer's disease ($p = -0.11$, $p < 0.001$) was associated with higher neurology referral. Higher diagnostic confidence was associated with plasma biomarker testing ($p = 0.20$ and 0.24 , both $p < 0.001$). For ongoing dementia care, 42% viewed ordering plasma biomarkers as a low priority, and 19% were unsure.

Conclusions: These early data offer an initial window into the emerging role of plasma biomarkers in primary care and show that diagnostic confidence is linked to both referral patterns and test use. As FDA approval and insurance coverage expand, future NDWS waves will provide unparalleled insight into how adoption evolves.

B160 Student Presentation

Home-Time Measurement and Use in Empirical Studies: An Evidence Mapping Review

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Background: Home time is increasingly used to evaluate the quality of life among older adults with diverse conditions and the quality of care delivered by health systems. It is a patient-centered measure, usually defined as number of days patients spent alive and in one's own home, e.g., days not in acute or post-acute facilities. Despite its potential, empirical applications vary widely in included settings, time intervals, and patient populations. We conducted a comprehensive evidence mapping review to characterize home time measurement over the last 15 years.

Methods: We searched peer-reviewed articles in MEDLINE, Embase, and Web of Science from January 2010 to July 2025. Observational, experimental, or mixed-methods studies involving adults that used home time measures for outcomes assessment or prediction were included. Pediatric studies were excluded to align with Medicare's use of home time for evaluation of the innovative model of care. Studies were required to include ≥ 2 types of health care facility settings as time not at home.

Results: We included 217 studies, most observational and from the U.S. Publications increased from 32 (2010-2019) to 185 (2020-2025). 77% of studies focused on older populations (≥ 65), with stroke, cancer, or at the end-of-life populations also prevalent. Home time was used as an outcome or a predictor and referred to as "days in community", "days alive and at home" or "healthy days at home". It was usually measured in 90- or 180-day intervals, anchored by the admission date with days in inpatient rehabilitation, skilled nursing facilities, emergency department, nursing home, long-term care, and hospice being subtracted. Data sources included claims, electronic health records, and surveys.

Conclusions: Literature shows growing interest in home time as a patient-centered outcome across diagnosis and specialties, yet substantial variation exists in its nomenclature, measurement, and data sources. This heterogeneity may limit comparability across studies and indicates remaining gaps in understanding which definition best reflects patients' experiences and preferences.

B161 Student Presentation

Anxiety and Depression Among Nursing Home CNAs Across Personal Caregiver Status

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Background: Healthcare workers caring for patients at work and dependents at home are at higher risk for negative outcomes (e.g., exhaustion, burnout, poorer mental health) than their non-dual-caregiving colleagues. Literature on CNAs is limited and little research to date has examined dual caregiving and specific mental health outcomes among CNAs whose caregiver role includes child or adult care recipients. The present analysis examined the effect of caregiving status on levels of anxiety and depression among nursing home

CNAs. **Method:** Data for this analysis was collected as part of a wider study examining resiliency among Wyoming nursing home CNAs. Participants ($n=286$) were 18-73 years old ($M=32.40$, $SD=13.01$) and the majority were White (82.5%), non-Hispanic (88.5%), or cisgender women (83.2%). They were split into two groups: caregivers ($n=163$; CNAs who care for a child and/or a non-child dependent) and non-caregivers ($n=123$). The PHQ-8 and GAD-7 assessed depression and anxiety, respectively. Chi-square tests of independence examined associations between caregiver status and meeting clinical thresholds suggestive of Generalized Anxiety Disorder (GAD; score ≥ 10) and Major Depressive Disorder (MDD; score ≥ 10). Exploratory t-tests examined differences in age and years of CNA experience across groups. **Results:** A chi-square test of independence indicated a significant association between caregiver status and GAD threshold in the opposite direction expected ($X^2(2) = 4.76$, $p = .029$). Non-caregivers were more likely than caregivers to meet GAD threshold (38.5% vs 26.4%). There was no significant association between caregiver status and MDD threshold ($X^2(2) = 2.78$, $p = .095$). Independent samples t-tests indicated that non-caregivers had fewer years of experience ($M_{diff} = -5.5$, $t(255) = -7.08$, $p < .001$) and were younger ($M_{diff} = -14.6$, $t(283) = -11.69$, $p < .001$) than caregivers. **Conclusion:** Differences across caregiver status on age and years of experience may explain the unexpected finding that non-caregivers exhibit greater anxiety than caregivers. Anxiety is most common and has increased most rapidly among younger US adults. Among nurses, less experience is linked to greater burnout and lower workplace satisfaction. Initiatives to improve well-being for nursing home CNAs may need to focus more on younger, less experienced CNAs or be adapted to best meet their mental health needs.

B162

Caregiver Ratings of End-of-Life Care in the Dementia Care (D-CARE) Study

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Background: The effect of dementia care management on end-of-life (EOL) care is poorly understood. We examined care and unmet needs during the last month of life among persons living with dementia (PLWD) who died during the D-CARE trial.

Methods: D-CARE was an 18-month, 3-arm, assessor-blinded pragmatic RCT at 4 US sites (June 2019-August 2023). Interventions included health system-based dementia care (HSDC) provided by advanced practice providers and community-based dementia care (CBDC) provided telephonically by a social worker, nurse, or therapist. Outcomes were caregiver ratings of overall EOL care (excellent vs. other), count of unmet needs in the last month of life (decisions without input, unwanted care, poor communication, lack of respect, or poorly controlled pain, dyspnea, or anxiety; range 0-7). Robust Poisson models adjusted for site were used to assess intervention effects. Analyses including usual care (UC) (location of death and hospice use) were exploratory due to few UC decedents.

Results: Of 2176 enrolled PLWD-caregiver dyads (1016 HSDC, 1016 CBDC, 144 UC), 514 PLWD (24%) died during the study (HSDC $n=254$, 25% of enrolled; CBDC $n=223$, 22%; UC $n=37$, 26%). Caregiver interviews about EOL care were completed for 438 decedents (85%). Decedents were 59% female, 84% White, mean age 83.3. Caregivers were 78% female, 40% spouses, 55% children, and 72% lived with the PLWD. Caregivers in both interventions reported few

unmet needs (<1 on average); means (95% CI), HSDC 0.81 (0.64, 1.04) vs. CBDC 0.78 (0.61, 1.00), $p=0.80$. Caregiver-rated EOL care was similar between interventions (probability of excellent rating (95% CI), HSDC 0.39 (0.30, 0.50) vs. CBDC 0.41 (0.32, 0.52), $p=0.60$). Probability of dying at home was the same for HSDC and CBDC 0.53 (0.43, 0.65) and lower in UC 0.38 (0.24, 0.58), $p=0.22$ for UC vs. CBDC/HSDC. Hospice use was similar across groups: HSDC 79%; CBDC 76%; UC 80%.

Conclusion: End of life outcomes did not differ between HSDC and CBDC; both produced high quality care with few unmet needs.

B163

Deprescribing Recommendations in Disease-Focused Clinical Practice Guidelines for Older Adults: An Expert-Driven Review

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Background: Deprescribing is a core component of medication optimization for older adults. Nevertheless, both the extent to which and how commonly used disease-focused clinical practice guidelines (CPGs) address deprescribing remains unclear.

Methods: We conducted an expert-driven review and synthesis of CPGs, which was preregistered on Open Science Framework. In collaboration with a panel of specialist and generalist experts, we selected 26 CPGs addressing the management of conditions highly prevalent in older adults (e.g., hypertension, osteoarthritis, etc.) that were considered widely used by clinicians in the United States. Each CPG underwent structured, keyword-based extraction to identify deprescribing-related content, drawing on synonyms related to deprescribing. We analyzed CPGs containing deprescribing content to characterize the nature and specificity of deprescribing guidance.

Results: Of 26 included CPGs, 15 (57.7%) contained at least one top-line deprescribing recommendation, yielding 34 discrete top-line recommendations. Of these 34, 25 (73.5%) focused on preventing future harm, 8 (23.5%) on mitigating drug side effects, and 11 (32.4%) provided guidance regarding duration of therapy after which deprescribing should be considered. Four recommendations (11.8%) explicitly referenced "older adults" or specified an age threshold, and 2 (5.9%) addressed deprescribing in the setting of limited prognosis. Half (17, 50%) offered some pragmatic instruction on how to deprescribe (including in text supporting the top-line recommendation), though most were vague and lacked operational detail (e.g., dynamics of stopping, taper schedule, alternative therapies).

Conclusions: Deprescribing is referenced in more than half of disease-focused CPGs commonly used in the care of older adults, yet recommendations are highly heterogeneous and often lack practical guidance. Greater standardization and clearer operational direction within CPGs may support safer, more systematic deprescribing for older adults.

B164

Palliative Care and Home Time Among Patients with Serious Illness: A Systematic Review

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Background: Home time is increasingly used as a person-centered outcome and quality indicator for end-of-life care. However, evidence on its association with palliative care is mixed, and no systematic reviews exist. This systematic review examines whether

palliative care is associated with greater home time among people with serious illness.

Methods: We conducted a systematic search in MEDLINE, Embase, and Web of Science databases for studies published between 2010 and 2025 that examined palliative care and home time among adults with serious illness. Two reviewers independently screened all abstracts and full texts, extracted data, and assessed risk of bias.

Results: Eight studies with 144,754 adults with serious illness were included. Most studies were retrospective cohorts (n=7); only one was a randomized clinical trial. Six studies included only decedents and all found that palliative care was significantly associated with more days at home; the two studies not limited to decedents reported no significant association. Palliative care models varied across clinical leadership (specialist-led n=3 versus primary care-led n=1), scope of implementation (single-center/program n=2 versus multi-site n=1), team structure (multidisciplinary n=3), and care delivery (integrated n=4). Studies varied in their definitions of days at home: all studies subtracted days in hospitals (n=8), and most also subtracted days in emergency departments (n=5) and post-acute rehab settings (n=4). Follow-up periods also varied across studies, ranging from the last 30-180 days of life to fixed windows after hospitalization.

Conclusions: This is the first systematic review to examine the relationship between palliative care and home time. While most included studies reported greater home time among decedents receiving palliative care, few studies met inclusion criteria and only one was a prospective trial. Limiting samples to decedents may bias the effect of palliative care on home time. Due to gaps in the evidence, high-quality studies are needed to evaluate the effects of primary and specialty palliative care interventions on home time for people with serious illness.

B165

Clinician Team in Dementia Care: Evidence from a Large, Academic Health System

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Background: Comprehensive dementia care relies on a team-based approach to address the complex needs of patients and caregivers and improve outcomes. However, the composition and structure of clinician teams involved in dementia care remain poorly understood. To address this gap, we analyzed data from a large academic health system to characterize dementia care teams and inform future efforts to improve care delivery.

Methods: Using 2021–2023 UT Physicians outpatient electronic health record data, we identified two patient cohorts: diagnosed dementia (n=1,940) and possible dementia (no diagnosis but prescribed acetylcholinesterase inhibitors or memantine; n=4,357). Possible dementia cases were then 1:1 propensity score-matched to diagnosed cases. For each cohort, we identified the clinicians caring for these patients and constructed clinician teams using network analysis by linking pairs of clinicians who shared at least one patient in that cohort. To compare clinician teams between cohorts, we constructed patient-level measures reflecting the number and specialty mix of clinicians a patient encountered, the connectedness of those clinicians to other clinicians through shared patients (clinician peers), and the extent of patient sharing among them (care density).

Results: Patients with diagnosed dementia saw more outpatient clinicians than those in the matched possible dementia cohort (Mean [SD]: 2.88 [2.64] vs 2.43 [2.28], p<.001). Among patients with ≥2 clinicians, 24.5% of patients in the diagnosed cohort were co-managed by primary care and dementia-related specialists, compared with 10.9% in the matched possible cohort (p<.001). Co-management

between dementia-related and other specialists was also more common in the diagnosed cohort (54.5% vs 32.5%, p<.001). Patients with diagnosed dementia also had clinicians who were more connected to other clinicians through shared patients (clinician peers: 111.55 [79.48] vs 36.43 [20.59], p<.001) and who shared more patients with one another (care density: 7.68 [16.8] vs 1.72 [3.03], p<.001).

Conclusions: Having a confirmed diagnosis of dementia is associated with differences in the size and composition of clinician teams. Future work will examine how different team compositions are associated with the quality of dementia care.

B166 Student Presentation

Comparative Electrophysiologic Safety of Suvorexant Versus Zolpidem in Older Adults With Insomnia: A Real-World Cohort Study

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Background:

Older adults with insomnia are frequently prescribed pharmacologic therapy, yet a comparative electrophysiologic safety profile between hypnotic classes remains under-researched. Zolpidem has been hypothesized to be associated with autonomic instability due to potential increased autonomic activation, often impacting the parasympathetic and sympathetic branches, which can reduce cardiac electrical stability. This study evaluated the incidence of new onset arrhythmias in older adults initiating suvorexant versus zolpidem for insomnia within a large real-world database.

Methods:

A retrospective cohort study was conducted using TriNetX Research Network. Adults aged 65 and older with insomnia who initiated suvorexant (Cohort A, n= 9,944) or zolpidem (Cohort B, n= 9,944) were included. Propensity score matching produced two balanced cohorts. Outcomes were assessed beginning 30 days after the index prescription through 5 years. Arrhythmia endpoints included atrial fibrillation, atrial flutter, ventricular tachycardia, ventricular fibrillation/flutter, and premature ventricular contractions (PVCs).

Results:

Suvorexant users had significantly lower rates of multiple arrhythmias compared with zolpidem users. Atrial fibrillation occurred in 5.47 percent versus 6.34 percent (RR 0.863, 95 percent CI 0.763-0.975; p=0.0181). Atrial flutter occurred in 1.48 percent versus 2.30 percent (RR 0.645, 95 percent CI 0.523-0.795; p<0.0001). Ventricular tachycardia occurred in 1.55 percent versus 2.08 percent (RR 0.746, 95 percent CI 0.604-0.921; p=0.0062) and PVCs in 3.76 percent versus 4.42 percent (RR 0.852, 95 percent CI 0.740-0.98; p=0.0251).

Conclusions:

Suvorexant was consistently associated with fewer clinically relevant arrhythmias compared with zolpidem across multiple electrophysiologic endpoints. Significant reductions were observed in atrial fibrillation/flutter and ventricular tachyarrhythmias. Collectively, the magnitude and consistency of these findings support a more favorable autonomic and electrophysiologic profile with orexin receptor antagonism relative to GABAergic hypnotics. Prospective studies are needed to confirm these real-world safety signals and further clarify mechanistic pathways.

B167

Associations of Chronic Kidney Disease with Brain-derived Tau Levels: A pilot study

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Background: Blood-based biomarkers of Alzheimer's disease (AD) have been developed to detect AD pathology. Brain-derived tau (bdTau) is a novel AD blood-based biomarker that is specific for AD-type neurodegeneration. Reduced kidney function affects levels of many AD blood-based biomarkers. The extent to which kidney function affects serum levels of bdTau is unknown.

Methods: The BRain IN Kidney Disease (BRINK) longitudinal cohort enrolled 554 community-dwelling participants aged 45 years and older with and without CKD from the Twin Cities, Minnesota. We measured levels of bdTau in 443 stored serum samples from the baseline BRINK study visit.

Results: Participants (mean age 69.2 years, 50.3% female, 15.9% African American) with reduced estimated glomerular filtration rate (eGFR) had higher bdTau levels than those with preserved eGFR (bdTau 54.6 pg/mL [SD 24.5] for eGFR <15 mL/min/1.73m², 34.2 [20.5] for eGFR 15-29, 22.9 [23.4] for eGFR 30-44, 16.8 [19.9] for eGFR 45-60, and 9.2 [9.1] for eGFR >60). The trend was consistent for all levels of cognitive impairment (from no cognitive impairment to severe cognitive impairment) and persisted following adjustment for demographics and comorbidities.

Conclusion: Lower eGFR was associated with increased serum levels of bdTau. Associations of eGFR with bdTau were not explained by degree of cognitive impairment. Kidney function needs to be considered when interpreting bdTau levels.

B168 Student Presentation

Hospital Alternate Level of Care Unit Integrating the "4Ms" may contribute to Improved Discharge Rate

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Background: Older adults, especially those with cognitive impairments and complex care needs, are disproportionately affected by discharge delays due to systemic, logistical, and social barriers. We evaluated whether establishing a dedicated Alternate Level of Care (ALC) hospital unit incorporating the 4Ms framework was associated with improved discharge efficiency.

Methods: We conducted a retrospective study of a novel 20-bed ALC unit at the University of Vermont Medical Center from 3/1/2024 to 2/28/2025. This unit is designed to care for patients who no longer require acute hospitalization but face non-medical discharge barriers. The 4Ms were operationalized as: individual activity planning based on patient values ("What Matters"), medication reviews and deprescribing ("Medications"), cognitive stimulating social activities ("Mentation"), and prioritizing movement ("Mobility"). Data collected included demographics, use of psychotropic PRN medications, Length Of Stay (LOS) Observed to Expected Ratio (LOS O:E) based on Diagnosis Related Group (DRG), and the percentage of total hospital acute care beds occupied by non-acute patients. Outcomes from the first six months of the study period were compared to those from the subsequent six months as pre-implementation data were not collected with this study design in mind.

Results: There were 85 medically stable individuals admitted to the ALC during the observed period (mean age 71 ± 13 years; 45% female, 53% male). Comparing the first 6 months to the second 6 month, use of prn psychotropic medications did not change, the LOS O:E decreased from 17.1 ± 7.6 in the first six months and 14.8 ± 11.1 in the last six months (p=0.68) and the percent of acute care beds in the entire hospital

occupied by non-acute patients decreased from 19.5% ± 1.0% in the first six months to 12.4 ± 2% in the second six months (p < 0.05).

Conclusion: This retrospective study demonstrates that implementing the "4Ms" framework within a novel ALC unit was associated with improvements in delayed discharge, including reduced LOS O:E based on DRG and reduced non-acute occupancy of acute care beds. These findings highlight the potential of age-friendly care principles to support broader implementation of this approach.

B169 Student Presentation

Nontraditional staffing model on a Hospital Alternative Level of Care unit improves costs while maintaining quality

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Introduction: Older adults, especially those with cognitive impairments and complex care needs, are disproportionately affected by discharge barriers resulting in prolonged hospital stays. The University of Vermont Medical Center (UVMHC) co-horted non-acute patients on an Alternative Level of Care (ALC) hospital unit with reduced staff to patient ratios with oversight by Geriatric clinicians to see if costs could be reduced while maintaining quality of care.

Methods: We conducted a retrospective study of a 20-bed novel ALC unit from 3/1/2024 to 2/28/2025. Costs were assessed per patient per day and compared to three other acute care units at the hospital. The unit was staffed with 2 Licensed Practical Nurses (LPN's), 3 Licensed Nursing Assistants (LNA's), 1 Advanced Practice Providers (APP's), as well as an Activities Coordinator and dedicated Care Management Social Worker. The setting allowed more social interaction and mobility than the acute care units. The Activities Coordinator engaged patients in group crafts, exercises and music, and the Social Worker intensively worked on discharge planning. Quality of care safety measures included healthcare associated complications (HAC's) like catheter associated urine infections (CAUTI), health care associated pressure injuries (HAPI) and fall rates.

Results: There were 85 non-acute individuals admitted to the ALC unit during the observed period (mean age 71 ± 13 years; 45% female, 53% male). The cost of direct care was \$50 less per patient per day compared to other acute medical units. The rate of CAUTI and HAPI was 0/1000 patient days. The rate of falls was 0.63/1000 patient days similar to 0.65-0.70/1000 patient days on the acute care medical units.

Conclusions: Co-horting non-acute patients on an ALC unit with a novel staffing model was associated with an estimated saving of \$1000/day (approximately \$365,000 per year) in direct patient care and without an increase in hospital acquired conditions.

B170 Resident Presentation, Encore Presentation

Optimizing Potentially Inappropriate Medications in an Age-Friendly Geriatric Oncology Clinic

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Background: Our previous work has shown that the Geriatric Oncology Potentially Inappropriate Medications (GO-PIMs) scale—adapted from National Comprehensive Cancer Network (NCCN) Guidelines regarding high-risk medications in older adults with cancer—is linked to frailty and adverse outcomes. Our VA Boston Geriatric Oncology Clinic (Age-Friendly-certified) was selected as one of 16 sites nationally to participate in the deprescribing initiative sponsored by the VA Center for Medication Safety. Our aim is to identify PIMs and optimize medications utilizing the GO-PIMs scale and clinical judgement in older Veterans with cancer.

Methods: This single-center, prospective quality improvement initiative is enrolling Veterans age ≥ 65 years with cancer who were seen in the Geriatric Oncology clinic from March 2025 to March 2026. The interdisciplinary team (a geriatrician, a pharmacy resident, oncology clinical pharmacists, and a palliative care nurse practitioner) is responsible for medication reconciliation, identification of GO-PIMs and other PIMs, and medication optimization—defined as medications deprescribed, dose adjusted, exchanged to an alternative, or continued though closely monitored. “Other PIMs” are medications not listed in the GO-PIMs scale but whose risks outweigh benefits as determined by shared decision making. Chronic medications and supportive oncology medications were reviewed for PIMs.

Results: To date, the medication optimization program has served 59 Veterans and evaluated 914 medications (mean 15.5 medications per Veteran, SD 5.9). Of these, 284 (31.2%) were identified as PIMs, with 110 (38.9%) GO-PIMs. Despite accounting for 11.3% of all medications, supportive oncology medications accounted for 24.3% of all PIMs, with the remaining 75.7% found in chronic medications. A total of 339 medication optimizations were recommended. 191 (56.3%) were continued with close monitoring. 96 (28.3%) of medications were deprescribed. 32 (9.4%) of the total PIMs were dose adjusted, and 20 (5.9%) of the total PIMs were exchanged to a safer alternative.

Conclusions: All Veterans enrolled met historic definition of polypharmacy (≥ 5 medications), and PIMs were prevalent. An interdisciplinary process, guided by the GO-PIMs Scale, is successful at identifying and optimizing PIMs in this vulnerable population.

B171

Mission-oriented strategies to advance inclusive communities at an academic geriatric department: A new direction

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Background: Academic geriatric medicine departments play a critical role in fostering equitable, inclusive environments for the workforce and the diverse older adults they serve. Building on several years of efforts within the Brookdale Department of Geriatrics and Palliative Medicine—including the transition of our diversity council into the Mission-Oriented Strategies to Advance Inclusive Communities (MOSAIC) Council—we sought to understand current departmental needs and priorities to guide the council’s next phase of growth. **Methods:** We distributed a 14-question online survey in mid-2025 to all department staff. The survey assessed familiarity with the council, perceived importance of its mission, priority areas for focus, expectations for council functions, communication preferences, and perceptions of psychological safety and inclusion. **Results:** Forty-one participants responded. Most respondents were somewhat (59%) or very (22%) familiar with the council. A strong council was viewed as very (42.5%) or somewhat important (42.5%). Respondents identified key priorities for the council, including policy review for equity (23%), retention and promotion equity (18%), training and education (17%), culture and psychological safety (16%), accountability and metrics (12%), and inclusive hiring (8%). Open-text responses emphasized the need for increased transparency around workload and compensation and expanded opportunities for department-wide conversations on inclusion and equity. Expectations for the council functions included deploying training (18%), advising leadership (16%), supporting affinity groups (14%), organizing events (14%), advising on hiring and promotion (10%), addressing bias or conflict concerns (13%), and monitoring key metrics (10%). Half of the respondents (51%) felt that any concerns raised to the council would be acted upon. A minority reported discomfort raising concerns (14.6%) or uncertainty that concerns would be adequately addressed (7.3%). **Conclusions:** Our findings offer guidance on the areas most

valued by our community: equitable policies, retention and promotion and psychological safety. The minority who expressed discomfort raising concerns underscores an ongoing need for trust-building and transparency.

B172

The Effects of Educational Intervention on Antipsychotic Administration

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Background

Acute agitation and delirium in hospitalized patients is a common occurrence, often precipitated by factors in the patient’s medical presentation, underlying risk factors, and new environment. Antipsychotic medications are often used to manage acute agitation, especially in hospital settings.

Methods

The purpose of this study is to evaluate the use of first-generation antipsychotics in inpatient hospital settings, with a focus in reducing use of these medications as first-line agents for delirium in older adults.

The study design is an analytic observational cohort study, set in Los Angeles General Medical Center (LA General). The study population are patients hospitalized inpatient from August 2025 - March 2026 at LA General. The intervention consists of a single-page educational material with information on identifying delirium, prevention of delirium, contributing factors and medications to delirium, and acute agitation management. First implementation occurred on 9/16/2025 to all inpatient housestaff senior residents through internal hospital secure system messaging.

Study measures are quantitative monthly assessments of the number of administrations of haloperidol, haloperidol LAI, olanzapine, quetiapine, risperidone, trazodone, obtained through electronic medical records of inpatient medication administration. PowerInsight, an operational tool from Cerner that provides analytics and reporting on clinical data from the Cerner Millennium EHR system, is used as the analytic procedure tool.

Results

From the start of August to the end of September, there was a 17% decrease in total administrations of haloperidol in this study population. In this same window of time, there was a 10% increase in total trazodone administration.

Conclusion

Early results indicate that standardized, concise educational material can effectively share information to housestaff resident seniors. This educational intervention may have far-reaching implications for first-line pharmaceutical management for acute delirium, as well as increasing early evaluation of delirium and implementation of non-pharmaceutical management strategies.

B173 Student Presentation

Predictive advantage of inpatient mobility assessments

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Background:

Inpatient immobility leads to worse outcomes and increased health care costs. The University of Kansas Health System (TUKHS) implemented the John Hopkins Activity and Mobility Promotion framework (JH-AMP) in place of the Bedside Mobility Assessment Tool (BMAT) to increase inpatient mobility. TUKHS also implemented Activity Measure for Post Acute Care (AM-PAC) to assess

mobility status and assist in discharge planning. We seek to compare the use of AM-PAC as part of the JH-AMP framework to BMAT for inpatient older adults at TUKHS. This study can help guide the implementation of criteria for frailty screening and intervention as required by the current CMS Quality Measure on Age Friendly Hospitals.

Methods: This is a retrospective chart review of patients age 65 or older admitted to two units at TUKHS in February-March of 2024 (BMAT period) and 2025 (AM-PAC period). Demographics, mobility scores, length of stay (LOS), and discharge destinations were collected. Sensitivities and specificities were calculated for discharge home using green as the cutoff for BMAT and 18 for AMPAC. Then, area under the ROC curves (AUC) were estimated to determine predictive performance for each mobility assessment. Logistic regressions were fit with primary predictors of BMAT and AMPAC controlling for age, LOS, and sex. AUCs were calculated from logistic regressions to determine if these demographics impact performance of the assessments.

Results: A total of 616 charts were reviewed. 288 for BMAT and 328 for AMPAC. Most patients were male (56%), the average age was 77 years, and average LOS was 5 days. AM-PAC had higher predictive ability (AUC 87%) compared to BMAT (77%). We saw a higher sensitivity (88%) and lower specificity (67%) in AMPAC compared to BMAT sensitivity (39%) and specificity (98%) ($p < .001$ for both). Adding demographics improved predictive ability to AUCs of 94% for the AMPAC and 89% for BMAT.

Conclusions: BMAT is more sensitive while AMPAC is more specific when determining discharge destination in older adults. When combined with patient-level data, mobility assessments become further predictive. Future studies are needed to further assess clinical application for inpatient discharge planning.

B174 Resident Presentation

Optimizing Inpatient Fecal Occult Blood Testing (FOBT) Use in Older Adults: A Retrospective Analysis and Quality Improvement Initiative

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Background

Fecal occult blood testing (FOBT) is often misused in the inpatient setting, particularly among older adults who are vulnerable to unnecessary procedures. FOBT is validated only for outpatient colorectal cancer screening, yet it is often used in hospital settings. This may trigger inappropriate downstream interventions and increased healthcare utilization. This study evaluates inpatient FOBT use and subsequent gastrointestinal (GI) investigations. Our goal is to identify targets for education and system-level change for inappropriate testing in the elderly hospitalized patient.

Methods

A retrospective analysis was done on hospitalized elderly adults at our hospital from January 1 2024 to January 23, 2025. Inclusion criteria: patients >65 years old with a diagnosis of gastrointestinal bleeding (active bleed, melena, hematochezia, etc) on all medical floors. A total of 320 patients were identified. Of these, further stratification took place with a documented FOBT order and evaluated whether patients had a subsequent GI consultation or underwent colonoscopy.

Results

Of 320 inpatients reviewed, 103 (32.2%) had FOBT ordered. Among them, 92 (89.3%) had a positive result.

Downstream utilization included:

75/103 (72.8%) receiving GI consultation

34/103 (33.0%) undergoing colonoscopy

Care pattern distribution:

27/103 received both GI consult and colonoscopy

48/103 had GI consult only

7/103 had colonoscopy without a GI consult

21/103 had no GI evaluation

Despite a high rate of positive FOBT results, more than 20% of patients received no additional GI workup, indicating inconsistent clinical decision-making and overuse or underuse of resources.

Conclusion

Inpatient FOBT ordering demonstrated significant variation and potential misuse of FOBT among older adults. The high rate of downstream GI interventions underscores the clinical implications of inappropriate testing. Findings support the need for provider education and revised order sets. With the above intervention, the implementation of a hard-stop will take place to restrict inappropriate FOBT ordering. A post-interventional analysis will be done to review the clinical impact of this measure. Targeting inappropriate FOBT testing in the elderly may meaningfully avoid unnecessary endoscopic evaluations, improve patient safety, and support more efficient, guideline-concordant clinical practice with reduction in healthcare costs.

B175

Longitudinal Evaluation of Frailty, Adverse Events, and Polypharmacy Among Geriatric Outpatients: Results from a One-Year Quality Improvement Initiative

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Authors: B. Eschenheimer, R. Horowitz, R. Sekandlapuram, A. Tharwani, R. Malik, R. Rothbaum, C. George

Institution: Albert Einstein College of Medicine, Bronx, NY

Background:

Frailty increases vulnerability to adverse outcomes such as falls, hospitalizations, and mortality. Although the Clinical Frailty Scale (CFS) is a validated tool, its clinical application and the documentation of frailty remain inconsistent. This QI initiative assessed the association between frailty status and one-year outcomes, polypharmacy trends, and documentation practices in the ambulatory geriatrics setting.

Methods:

A one-year follow-up of 40 geriatric outpatients previously screened with the CFS was conducted. Patients were previously categorized as frail (CFS >4) or non-frail (CFS ≤4). Outcomes assessed included falls, emergency department (ED) visits, hospitalizations, mortality, medication burden, and frailty documentation. Descriptive statistics, Independent sample T-test, and Chi Square was used for statistical analysis

Results:

Of 40 patients, 62.5% were frail, and frailty documented in 55% of charts. The mean age (SD) 80 ± 7 , 65% females, 35% Black, 15% White, 2.5% Asian and 40% Hispanic. The prevalence of HTN was 85%, DM 27.5%, CHF 17%, COPD 17%, cancer 17%, dementia 50%, osteoarthritis 42.5%, and average number of medications was 8.5. At 1 year follow-up, falls without injury were significantly higher among frail patients (32% vs 6.7%, $p=.047$) than non-frail. Frail patients had more total falls (36% vs. 13.5%; $p=.058$), ED visits (40% vs. 13.3 %; $p=.052$), and hospitalizations (64% vs. 40%; $p=.427$), though differences were not statistically significant. Mortality was similar (8% vs 6.7%; $p=1.000$). Average medication count rose from 8.5 ± 4.8 at baseline to 11.8 ± 5.5 at one year, with frail patients on slightly fewer medications (11.6 vs 12.0 , $p=.85$) than non-frail.

Conclusions:

Frail patients experienced more falls and adverse events, underscoring the need for additional targeted fall prevention strategies. Rising polypharmacy and limited documentation highlight areas for further QI intervention. Standardized CFS documentation and follow-up protocols may improve care outcomes for frail older adults.

B176 Student Presentation

From Bedside to Phone Call: What Empathy Interviews Reveal About Polypharmacy Perception in Older Adults

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Background:

This study explored the lived experiences of hospitalized older adults and their families regarding polypharmacy using Human Centered Design principles to inform a patient-centered deprescribing intervention.

Methods:

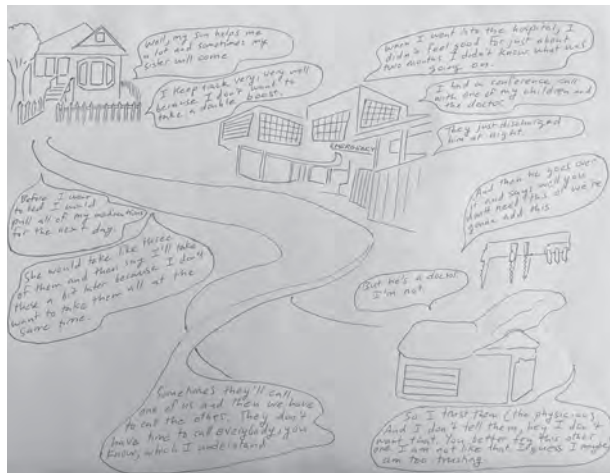
We conducted a participatory, qualitative study using empathy interviews—semi-structured, one-on-one conversations with patients aged 80 or greater admitted to a hospital unit and meeting polypharmacy criteria (≥ 5 medications) with one medication being identified as a Potentially Inappropriate Medication (PIM). Interviews conducted bedside (May–July 2025) and by phone (August–September 2025).

Results:

Eleven empathy interviews were completed with seven patients and four patients' Power of Attorney. Themes included: (1) caregiver involvement in medication management, (2) high trust in clinicians leading to passive patient roles, (3) communication breakdowns during hospitalization and discharge, and (4) emotional burden and vulnerability post-discharge.

Conclusions:

HCD findings support integration of patient and caregiver voices in clinical practice, education, and policy to promote safer, more equitable medication management for vulnerable populations.



The Road to Polypharmacy

B177 Student Presentation

AI vs Human Abstraction of Pain Scores in Osteoarthritis Patients Receiving Low-Dose Radiation Therapy

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Background:

Manual chart abstraction is labor-intensive and prone to variability. Artificial intelligence (AI) may improve efficiency and consistency of outcomes research. We evaluated Microsoft Copilot AI vs. human reviewers in extracting Numeric Rating Scale (NRS) and von

Pannewitz Score (VPS) pain metrics from patients receiving low-dose radiation therapy (LDRT) for osteoarthritis.

Methods:

Clinical notes from 26 patients were reviewed in a HIPAA-compliant environment. Human reviewers and Copilot AI independently extracted NRS (0–10) and VPS (0–4) at baseline, end of treatment (EOT), and ~1-month follow-up. Discrepancies were categorized as exact match, minor (≤ 2 -point difference), or missed. Agreement was assessed with intra-class correlation coefficient (ICC) for NRS and weighted kappa for VPS. Time per chart was recorded.

Results:

Of 78 NRS values, 92% were exact matches; 8% were minor discrepancies. VPS matched 94%. ICC for NRS was 0.96 (95% CI: 0.93–0.98), and weighted kappa for VPS was 0.91. AI abstraction averaged 2 minutes per chart vs. 30 minutes for humans. No major errors or hallucinated values occurred; one human error was corrected by AI. Discrepancies stemmed from contextual interpretation.

Conclusions:

AI-based abstraction achieved near-perfect concordance with human reviewers for pain outcomes, with vastly improved efficiency. These findings support AI integration into retrospective research workflows, potentially accelerating outcomes reporting in geriatrics and radiation oncology.

B178

Integrating the 4Ms into Physician Rounding Forms: Advancing Age-Friendly Care in a Rural North Dakota Nursing Home

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Background: Quality improvement initiatives are essential for nursing homes, which often face barriers such as limited staffing, resource constraints, and geographic isolation that can hinder implementation of evidence-based practices. Richardton Health Center, a skilled nursing home in North Dakota, achieved Level 1 and Level 2 AFHS recognition and sought to embed these principles into clinical workflows by updating its physician rounding form.

Methods: In summer 2025, an interdisciplinary team launched a QI project to revise the physician rounding form. The Assistant Director of Nursing prepares rounding forms that are updated by the physician during rounds and used to guide dictation. Existing documentation was assessed for gaps in addressing the 4Ms and a revised form was designed to prompt discussion of resident goals, medication safety, cognitive status, and mobility around the 4Ms framework. Physicians and nursing staff received targeted education on the updated process. Compliance was evaluated through chart audits and clinician feedback.

Results: The new form has been utilized correctly 100% of the time. Providers report improved ability to maintain accurate care plans and value having updated BIMS and PHQ-9 assessments with prior results for comparison. They also appreciate the review of PRN medication usage and identification of diagnoses that may no longer be pertinent, enabling timely discontinuation of unnecessary medications or outdated diagnoses. This process supports more thorough care and ensures plans remain current. Clinicians noted improved clarity in care planning and stronger alignment with resident priorities. Quality metrics tracked monthly demonstrated positive trends: residents with worsening independent mobility decreased by 10.2%, behaviors affecting others decreased by 6.4%, medication errors declined, and the facility's CMS 5-Star Quality Measures rating improved from 2 to 3.

Conclusions: Integrating the 4Ms into rounding forms is an effective and impactful strategy for sustaining Age-Friendly principles in rural nursing homes. This initiative strengthened person-centered care by improving comprehensive care planning and offers a replicable model for facilities committed to enhancing outcomes for older adults.

B179 Resident Presentation

Increasing Osteoporosis Screening in High-Risk Men Aged 70 Years and Older Through a Pharmacist- Led Intervention

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Background: Men aged 50 years or older have a 13% to 30% lifetime osteoporotic fracture risk and a two to threefold higher mortality rate from hip fracture compared to women. However, national guidelines differ in recommendations for osteoporosis (OP) screening in men, leading to inconsistent care. This project evaluated the impact of a pharmacist-led intervention on increasing Dual-Energy X-ray Absorptiometry (DXA) screening rates among male Veterans aged ≥ 70 years with OP risk factors.

Methods: This single-center, prospective quality improvement project was conducted in a VA geriatrics primary care clinic. Utilizing a locally developed VA dashboard that is designed to identify OP screening candidates, the pharmacist evaluated men at highest risk due to age ≥ 70 years and at least one OP risk factor. For eligible Veterans, a chart review note assessing validated OP risk factors, vitamin D supplementation, and DXA eligibility was entered into the electronic medical record. Providers and nurses were alerted to pharmacist recommendations. The primary endpoint was the number of DXA scans ordered within two months of chart review. Secondary endpoints included the number of Veterans requiring vitamin D management and the rate of pharmacist recommendation acceptance. Descriptive statistics were used for analysis.

Results: Forty-one Veterans met inclusion criteria (mean age 81; 59% Black) with an average of 2 risk factors. The most common risk factors were diabetes (36%) and use of medications associated with OP (29%). Following pharmacist review, 24/41 Veterans (59%) had DXA scans ordered, and 15/41 (37%) completed scans within 2 months. Vitamin D recommendations were provided for 16/41 Veterans (39%), and 9/16 (56%) were implemented by providers.

Conclusion: A pharmacist-led intervention using a clinical dashboard increased DXA scan ordering and improved vitamin D management among at-risk men aged ≥ 70 years within a VA geriatric primary care clinic. Veteran goals and life expectancy were not assessed in this project and may have impacted the uptake of pharmacist recommendations. The gap between scans ordered and those completed by Veterans suggest that additional follow-up measures may improve completion rates. These results highlight the important role of pharmacists in advancing OP screening and prevention in geriatric care settings.

B180

Educational and EMR Interventions to Improve Advance Care Planning Documentation and Billing

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Background: Advance care planning (ACP) is essential for delivering high-quality, goal-concordant care; however, only about one-third of adults have completed ACP. CMS introduced ACP billing codes to incentivize clinicians; however, rates remain suboptimal. Barriers include time limitations, insufficient training on documentation/billing, lack of institutional prioritization, and workflow inefficiencies. To address these challenges, we implemented educational interventions and a structured note template to improve ACP documentation/billing in an academic Geriatrics-Palliative Care practice.

Methods: This quality initiative was implemented in 1/2023, and outcomes were analyzed quarterly through 9/2024. Educational interventions included quarterly training in ACP documentation/billing, guidance on accessing existing ACP documentation in the medical record, and review of individual provider ACP documentation/billing

performance. The EMR intervention involved collaboration between inpatient and outpatient providers to design an outpatient note template that streamlined documentation, ensured capture of essential clinical and billing elements, and remained easily visible across care settings. Outcomes included documented ACP notes, ACP bills submitted, and revenue added.

Results: The proportion of ACP documentation amongst established patients increased steadily across all seven quarters, rising from 5.1% in Q1 to 8.7% in Q7, an increase of +3.6% ($\beta = 0.65\%$ per quarter, $p < 0.001$). Rates of new patients with a submitted ACP bill showed non-linear quarter-to-quarter fluctuations, increasing overall from 6.2% in Q1 to 7.4% in Q7, and reaching as high as 12.6% in Q5. Across the study period, 924 ACP bills were submitted, generating approximately \$69,903 in additional revenue.

Conclusions: Historically, ACP conversations have occurred at a higher rate than they are billed, resulting in missed reimbursement opportunities. Given the time-intensive nature of geriatric and palliative care, clinicians working in fee-for-service environments face challenges receiving compensation for the comprehensive care they provide. By promoting accurate ACP documentation and billing, this initiative not only supports high-quality care but also improves alignment across clinical services and enhances revenue capture for health systems.

B181 Resident Presentation

Retrospective descriptive analysis of geriatric Veterans started on osteoporosis treatment in the community living center (CLC) at the VA Sierra Nevada Healthcare System

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Background: Osteoporosis is prevalent in the VA population but remains undertreated. To address this gap, pharmacists at our facility initiate guideline-recommended treatment in eligible veterans admitted to the CLC though it is unclear if therapy is continued post discharge. Poor adherence is a known challenge to osteoporosis treatment and increases risk of fractures and mortality. Monitoring osteoporosis therapy is also crucial to ensure treatment effectiveness. Guidelines provide recommendations on duration of pharmacotherapy, drug holidays, sequential therapy, and monitoring. The purpose of this quality improvement project is to determine if Veterans started osteoporosis therapy in the CLC were continued on treatment post discharge with appropriate follow-up, monitoring and duration of therapy to identify any gaps in care. **Methods:** Veterans newly started on osteoporosis medications within the CLC and discharged to outpatient management from Jan 2017 to Jan 2025 were included. Osteoporosis medications included alendronate, zoledronic acid, denosumab, and teriparatide based on VA formulary. A structured query language (SQL) database and chart review were utilized to obtain data for demographics, medications, dual energy X-ray absorptiometry (DXA) results, FRAX scores, adherence rates, fractures, and labs including calcium, iPTH, phosphorus, vitamin D, and Scr. We described adherence to prescribed therapies after discharge and compliance with guideline recommendations for monitoring. **Results:** A total of 61 veterans (90.7% male; median age 78 years) were analyzed for treatment adherence; 26 received zoledronic acid, 33 alendronate, and 2 denosumab. Only 5 veterans completed the guideline-recommended treatment duration. Non-completion was primarily due to lack of provider follow-up (21, 33.5%), goals-of-care decisions (4, 6.4%), death prior to completion (14, 23.0%), or loss to follow-up (3, 4.9%). Among 37 veterans prescribed at least one year of treatment, only 2 had repeat DXA within 1-2 years of treatment. **Conclusions:** Our findings suggest poor outpatient adherence to osteoporosis medications and compliance with guideline-recommended monitoring. Efforts to improve osteoporosis medication adherence and monitoring will include enhancing patient and provider education, interdisciplinary collaboration as well as developing monitoring protocols.

B182

Transforming Geriatric Care Through Resident-Led Quality Initiatives

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Background: Our Family Medicine residency program launched collaborative Quality Improvement (QI) projects to address two priorities: enhancing care for older adults and meeting ACGME requirements for resident QI participation. Using the Institute for Healthcare Improvement's (IHI) Age-Friendly Health Systems 4Ms framework—What Matters, Medication, Mentation, and Mobility—residents engaged in team-based efforts to identify gaps, design interventions, and evaluate outcomes. This approach strengthened systems-based practice skills while advancing person-centered geriatric care.

Methods: PGY2 and PGY3 residents lead QI projects as part of their clinical team roles. Each team focused on one “M” while collectively applying all four across our ambulatory practice. Residents created an Epic EMR smartphrase for well-adult visits (age 65+) to prompt 4Ms-aligned care. Over three months, teams rotated responsibilities for documentation review, smartphrase tracking, and measuring care alignment. Data included patient priorities, care adjustments, and SDOH screening during the second PDSA cycle, with resources provided for positive screens. All data were compiled securely, used to complete the 4Ms Care Description worksheet, and submitted to IHI for review.

Results: In six months, 4Ms care was documented for 143 older adults. We identified 27 patients at high fall risk and implemented interventions; 21 patients screened abnormal on MiniCog and were referred for further testing. Numerous high-risk medications were adjusted or discontinued. “What Matters Most” was documented for all patients. Teams also addressed SDOH factors such as food and transportation insecurity for 25 patients. As a result of the project initiatives, our practice earned IHI Level 2 Age-Friendly Health System recognition.

Conclusions: This initiative aligned evidence-based geriatric care with ACGME requirements, improving outcomes and resident competency. Our model offers a replicable approach for other programs seeking to enhance care for older adults while achieving national recognition.

B183

Age-Related Patterns in Behavioral Emergency Response Team Activations Among Hospitalized Adults

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Background: Behavioral Emergency Response Teams (BERTs) are increasingly used in hospitals to manage behavioral dysregulation, particularly among older adults with delirium or neurocognitive disorders. As in delirium management, first-line management is nonpharmacologic, while medications are reserved for safety-critical situations. Despite frequent BERT activations in older adults, little is known about indications for activation and the interventions used to manage these events.

Methods: We retrospectively analyzed 546 BERT events at an academic medical center over a 6-month period (Sep 2024–Mar 2025). We extracted data from the electronic health record and existing datasets including patient age, BERT activation indication, comorbidities, and interventions used. We stratified events by age (18–64, 65–74, 75–84, 85+) to compare relevant comorbidities and intervention types. A two-member panel categorized BERT indications.

Results: Of 546 BERT events, 65% (n=356) BERT events were for patients ≥65 years. 83.9% (n=299) of these events involved patients who had delirium or a neurocognitive disorder versus 31.6% (n=60) of those <65 years old (p=0.01). Increasing age was associated with higher prevalence of having both (65-75: 20.6%, 75-85: 29.8%, >85: 38.2%; p=0.01) or either conditions (65-75: 73.0%, 75-85: 88.7%, >85: 92.1%; p=0.01). The most common BERT indications were physical aggression (45.6%, n=161) followed by being out of bed (38.3%, n=137). Pharmacologic interventions were more frequent among patients ≥65 years old (56.2%, n=200 of 356) compared to those <65 years old (40.5%, n=77 of 190) (p=0.01).

Conclusions: Most BERT events occurred in patients ≥65 years with an age-related increase of having delirium and/or neurocognitive disorder. Physical aggression and being out of bed were the most common triggers. Older patients received more pharmacologic interventions, which carry greater risks of adverse events. System-level strategies to reinforce nonpharmacologic approaches may reduce medication use and improve care in hospitalized older adults.

B184

Prevention or Overprotection?: Deprescribing Aspirin & Clopidogrel in Older Adults.

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Background:

Inappropriate or prolonged use of antiplatelet therapy—including aspirin, clopidogrel, and dual antiplatelet therapy (DAPT)—is common among older adults in various care settings. Over-the-counter availability of aspirin complicates deprescribing efforts, and DAPT is often extended beyond guideline-recommended durations. These practices increase bleeding risk without proportional cardiovascular benefit. The 2023–2024 AHA/ACC guidelines provide clear indications for antiplatelet therapy.

Objective:

To reduce inappropriate prescribing of aspirin and/or clopidogrel by 15% over 12 weeks at the Long Island State Veterans Home at Stony Brook University (LISVH at SBU), a 350-bed long-term care facility, through chart audits, provider education, and guideline-based protocols.

Methods:

A pharmacy-led review identified 175 antiplatelet prescriptions among 155 residents (including 20 on DAPT). Charts were audited for guideline adherence, and providers received feedback and education. Prescriptions lacking clear indications were flagged for discontinuation or further review.

Results:

Initial audit revealed 65 prescriptions without clear indications. After provider review, 13 were confirmed inappropriate; 11 were discontinued, and 5 remained due to patient refusal or pending specialist input. Ultimately, 157 prescriptions (89.7%) were appropriate. Inappropriate prescribing decreased by 84.6%, surpassing the 15% reduction goal.

Conclusion:

Targeted chart audits and provider education significantly reduced inappropriate antiplatelet use, mitigating bleeding risk without compromising cardiovascular benefit. Ongoing interventions, including periodic medication reviews and transitions-of-care protocols, aim to sustain improvements, and further reduce polypharmacy.

B185

Artificial Intelligence for Geriatrics Interdisciplinary Care Planning

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Background: Geriatrics interdisciplinary care planning is challenging and time intensive. Large Language Models (LLM), a form of generative artificial intelligence, has rarely been described for this purpose.

Methods: We used a comprehensive case study from the 2024 regional 1-month long interprofessional student geriatrics case competition led by the two Midwestern academic health centers. We abstracted the care plan recommendations from the winning team's 31-minute video presentation, that had students from physical therapy, health administration, dietetics, advanced practice nursing, dentistry, and psychology. Two geriatricians then iteratively developed a prompt for VA GPT, describing a similar team and full 7-page case study with a request for a care plan. We then compared the care plans from the case competition and VA GPT for similarities and differences plus measures of quality.

Results: Both care plans covered all active medical issues, such as diabetes, hypertension, urinary incontinence, anticoagulation, and falls. Both addressed health maintenance, such as osteoporosis screening, dental care, and nutrition. Both considered issues beyond the medical focus, such as caregiver issues, mental health and dentistry. Key differences were noted in medication management, with students recommending more changes consistent with best practice guidelines, such as avoiding sulfonylureas, changing to a more effective statin, and stopping unneeded iron and B12 deficiency supplements. Only students recommended advance care planning, an emergency response system, chaplaincy, and application for programs such as Medicaid waiver programs or PACE. Only VA GPT addressed sleep disturbance and recommended geriatric medicine consultation. Both care plans scored near-perfect on measures of clarity, accuracy, relevance, depth, and ease of understanding.

Conclusions: The LLM (VA GPT) synthesized a lengthy case and developed a comprehensive care plan in less than 5 minutes similar to that of an interprofessional student team that spent many hours over a month. Depending upon the prompt, an LLM may be less likely to recommend changes in medication management and less likely to recommend new care system enrollment. Further study of LLM's in care planning should consider optimal prompts and review of medical record notes to assist individuals and teams in care planning.

B186

Impact of Home-Based Primary Care on Place of Death for Patients Enrolled in Virginia at Home

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Background: Studies have shown that end-of-life care is more likely to be concordant with a patient's wishes if it is received at home.¹ The percentage of Medicare beneficiaries dying at home has increased, with 61.6% of Medicare beneficiaries dying at home in 2019 compared to 40.1% in 2015.^{2,3} However, there is a paucity of research evaluating the role of home-based primary care programs in ensuring goal-concordant care at the end of life, including place of death. We therefore sought to evaluate if participation in Virginia at Home (VaH), University of Virginia's home-based primary care program for medically complex older adults, was associated with increased rates of patients dying at home or center for acute hospice care.

Methods: Data was collected on patients enrolled in the VaH program who died between 2020-2024. Patient characteristics included age, length of participation in the program, degree of frailty (assessed via the Clinical Frailty Scale (CFS)), severity of caregiver burden

(as determined by the Zarit Burden Interview), and place of death. Place of death was defined as at home (patient's home or center for acute hospice care) or inpatient (hospital or skilled nursing facility). The T-test was used for analysis. Excel (Redmond, WA) was used. This study was IRB exempted by the University of Virginia Institutional Review Board, designated as quality improvement and program evaluation.

Results: One-hundred and nine patients were included in the analysis. Eighty-nine of the one-hundred and nine (82%) patients died at home. Available demographic data was similar between those who died at home vs inpatient including age at enrollment (84 yo vs 81 yo, NS) and average length of program participation (14 mo vs 13 mo, NS). Seventy-nine percent of the cohort had Zarit scores, and ninety-nine percent of the cohort had CFS scores available for analysis. There was no significant difference in median Zarit scores (12 vs 15, NS) or in median CFS scores (6.5 vs 6, NS) between those dying at home versus inpatient.

Conclusions: Enrollment and participation in VaH's home-based primary care was associated with higher rates of patients dying at home compared to national averages. This suggests that patients with greater burden of disease and need for caregiver support were equally likely to die at home when enrolled in VaH. These findings support the important role of home-based primary care in achieving goal-concordant end of life care.

B187 Encore Presentation

Strengthening Surgical Readiness for Older Adults with a Standardized 4Ms-Driven EMR Template

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Background: By 2050, the nearly 89 million adults aged ≥65 are projected to account for up to 31% of surgical cases. Clinical practice guidelines from the American Geriatrics Society and the American College of Surgeons recommend routinely addressing the 4Ms (What Matters, Medication, Mentation, Mobility) of Age-Friendly Health in perioperative care. Yet, access to preoperative providers with geriatrics expertise remains limited. At Froedtert & Medical College of Wisconsin (F&MCW), a system-wide preoperative history and physical (H&P) template exists within the electronic medical record (EMR). This template addresses delirium but lacks other 4Ms components. We sought to improve this template using the 4Ms framework.

Methods: Creation of a 4Ms based preoperative H&P template utilized input from a needs assessment process encompassing learner and institutional needs, interprofessional team members and key stakeholders' input, and perioperative clinical practice guidelines. Our interprofessional team then partnered with our institution's EMR personnel to create a geriatrics 4M focused preoperative template with health system availability in EPIC.

Results: 35 interprofessional perioperative providers participated in the needs assessment meeting. The geriatrics template was completed in November 2025. The template automatically appears in the preop H&P for patients aged ≥ 80 and contains 5 selectable elements that align with the 4Ms: 1) Delirium (Mentation), 2) Frailty (Mobility), 3) Central Polypharmacy (Medications), and 4) Advance Care Planning (what Matters most). The previous H&P template only addressed delirium (mentation). Each element contains guidance to users on appropriate assessment and plan selections, with multiple elements available for selection. The template is also available in a separate section for clinicians to use in patients less than 80 years old when indicated.

Conclusion: Successful creation of a scalable geriatrics preoperative EMR resource is possible through a collaborative, interprofessional approach. Future efforts include case-conference sessions to increase clinician awareness of the template and demonstrate its utility. Refining the template based on usage data and learner feedback will follow.

B188

Reducing Prescription Refill Requests Through Optimized Prescribing Practices

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BACKGROUND:

Medication refill requests can be time-consuming, disruptive to clinic workflows, and present safety risks when the filling prescriber lacks adequate knowledge or time to review a patient's history. At a large outpatient geriatric primary care practice that writes over 13,000 prescriptions and receives over 8,000 refill requests annually, we conducted a survey to understand providers' behavior and knowledge regarding refills. We describe a quality improvement project to reduce prescription refill requests through optimized prescribing practices with the goal of improving efficiency and safety.

METHODS:

We developed and conducted an online survey of 22 outpatient geriatric primary care providers about their approach to prescriptions and refills for both non-controlled and controlled substances. We also tested their knowledge of state and federal laws on controlled substances. We utilized aggregate electronic medical record (EMR) prescription data to establish baseline prescribing practices at the clinic prior to the quality improvement intervention.

RESULTS:

Clinic providers spend an average of 15 minutes per workday refilling medications. 83% of providers send a 90-day prescription with three refills for long-term non-controlled medications, which they perceive as most convenient for their patients. However, 83% of providers prefer to refill long-term controlled substances with a 30-day prescription and zero refills; most providers were not familiar with federal laws allowing refills for some categories (Schedules III-V) of commonly prescribed controlled substances. Providers were less likely to send long-term refills when covering for another provider. EMR data revealed that of 14,031 prescriptions over a one-year period, 26% had zero refills, 20% had 1 or 2 refills, and 54% had 3 or more refills. 8.9% of prescriptions were for controlled substances.

CONCLUSION:

We identified several opportunities to improve refill workflow and potentially improve safety: (1) educating providers on federal controlled substance laws to reduce refills performed by covering providers who are less familiar with the patient; (2) educating providers on the benefits of annual prescriptions for long-term non-controlled substances; (3) creating a consensus protocol for all clinic providers.

B189 Student Presentation

Association Between Number of Guideline-Directed Medical Therapy Prescription Classes and 30-Day Returns to Hospital Among Admissions Aged 75+ with Heart Failure and Chronic Kidney Disease

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Background: Heart Failure (HF) and Chronic Kidney Disease (CKD) are common in older adults (age 75+) and linked to poor outcomes. Guideline-directed medical therapy (GDMT) for HF involves 5 classes (ACEi/ARBs/ARNIs, beta-blockers, MRAs, SGLT2 inhibitors, and diuretics). We aimed to determine the association between the number of GDMT classes prescribed at discharge and 30-day hospital return rates in admissions aged 75+ with both HF and CKD. We hypothesized that a higher number of GDMT classes would be associated with a lower return rate.

Methods: This was a retrospective, secondary analysis of a quality improvement database from a 400-bed community teaching hospital (2017–2020) reviewed and approved by the Florida Atlantic

University IRB. The study included 2,637 hospital admissions aged 75+ with ICD-10 codes for both HF and CKD, excluding in-hospital deaths and discharges to hospice. Admissions were categorized by the number of GDMT classes (0–5) prescribed at discharge. Groups were compared using Chi-square or Fisher's Exact Test ($p < 0.05$ considered significant).

Results: In our cohort of 62,222 total admissions, 2,637 admissions had both HF and CKD. Out of these 2,637 admissions, the most common number of GDMT classes prescribed was two (37.5%). For admissions returning to the hospital within 30 days, the most common number was four (36.2%). Compared with admissions prescribed 0 GDMT classes, those prescribed 1, 2, or 4 classes were significantly more likely to return within 30 days ($p = 0.01, 0.04, 0.02$, respectively). Admissions prescribed 3 or 5 classes did not differ significantly from the 0-class group ($p = 0.46, FET = 0.58$).

Conclusions: Contrary to our hypothesis, older adults (75+) with HF and CKD discharged on a higher number of GDMT classes had a higher 30-day hospital return rate. This suggests that the current management approach for this complex, multimorbid population may be poorly standardized and requires individualized tailoring rather than simply maximizing the number of GDMT classes. Limitations include the possibility that sicker patients may be prescribed more medications (confounding by indication). Future research should focus on optimal combinations of GDMT and appropriate patient selection, especially in diverse older populations.

B190 Resident Presentation

Supporting Those Who Care: Early Needs Assessment to Guide a Dementia Caregiver Resource Hub

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Background

Dementia caregivers often experience significant stress and uncertainty, especially when local resources are difficult to locate. A recent encounter with a caregiver who felt overwhelmed and unaware of available support highlighted similar gaps in my own knowledge of Stillwater resources. This suggested a need for accessible, centralized information on dementia education, respite options, and community supports. We initiated a quality improvement project to assess caregiver needs and guide development of a community-focused dementia resource website.

Methods

Caregivers attending a community dementia event completed a brief survey assessing: (1) prior exposure to resources, (2) information needs, (3) success in finding needed information, (4) perceived usefulness (1–5), (5) caregiver burden (0–10), and (6) conditional qualitative feedback for those who did not fully find what they needed. Descriptive statistics were used. Findings informed priority content for the planned website. Next steps include collecting additional feedback through the site and monitoring website usage (visits and category-specific page access) to guide iterative improvement.

Results

Twenty-five caregivers responded; 96% were first-time users of local resources. Eighty percent found the information they needed; 20% found it “partly.” The most frequently selected needs were dementia education (84%), respite help (36%), support group options (32%), behavioral management (24%), and community services (24%). Perceived usefulness was high (mean 4.58/5; 68% rated 5). Caregiver burden was significant (mean 6.61/10; median 7), with 55.6% reporting burden ≥ 7 . Among those who answered “Partly” on perceived usefulness, comments emphasized the need for clearer educational materials and for help navigating support options.

Conclusions

Preliminary findings show substantial caregiver burden and strong demand for dementia education, respite information, and

support groups. These results support development of a centralized digital resource hub. A prototype website is in progress with additional data to be collected through online surveys and website analytics. Updated results, including early website usage patterns, will be made available at the Annual Meeting.

B191 Student Presentation

Implementing an Emergency Department Dementia Detection Algorithm Across Health Systems

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Background: Dementia is under-recognized more than 50% of the time in emergency care, risking unsafe discharges and avoidable rehospitalizations. The Emergency Department Dementia Algorithm (EDDA), previously developed and validated at Yale using structured electronic health record (EHR) data, demonstrated strong discrimination for identifying probable dementia. However, its generalizability to other health systems and implementation implications of model complexity remain uncertain.

Methods: We tested the feasibility of adapting EDDA for implementation in a second health system. EDDA was retrained on NYU EHR data using clinical and utilization features, evaluated at both patient- and visit-level representations with logistic regression, random forest, and XGBoost models. Data were split into training (80%), validation (10%), and test (10%) sets. Performance was examined under increasing feature complexity, using area under the receiver operating characteristic curve (AUC), sensitivity, specificity, and negative- and positive-predictive value (NPV and PPV) at probability thresholds of 0.1 and 0.5.

Results: NYU included 129,414 ED visits from 76,327 patients aged ≥ 65 , between 1/2023-6/2024 (median age 76 years [IQR 70-83]), with lower dementia prevalence than Yale (3.7% vs. 12.5%). Model performance was similar across approaches, with more features improving discrimination (AUC 0.87-0.89). Random forest achieved the highest sensitivity of 0.63 at a screening-relevant threshold (0.1), but had the lowest sensitivity of 0.08 at a conservative threshold (0.5). NPV remained high (≥ 0.96) across thresholds, supporting safe exclusion of low-risk patients, whereas lower PPV (0.2-0.7) reflected reduced prevalence. Across both sites, age, dementia medications, comorbidities, and neurologic care were top features, but their relative importance varied by site, reflecting differences in coding practices and patient mix.

Conclusions: EDDA generalizes well across sites but exposes tradeoffs between model simplicity and clinical utility. In low-prevalence ED settings, simpler models may offer practical advantages for deployment, underscoring the need for local retraining. Future work is needed to assess longer timeframes and prospective calibration.

B192 Student Presentation

SNF 30-Day Readmission/ED Revisits Under the Microscope: Gaps and Solutions

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Background:

As healthcare systems transition to value-based care, improving post-discharge outcomes is crucial. Patients discharged to skilled nursing facilities (SNFs) face an increased risk of 30-day readmissions and emergency department (ED) revisits, which not only negatively impacts their quality of life and care, but also leads to increased costs for the health system. This project aims to analyze SNF readmissions in real time to identify their causes and develop effective prevention strategies.

Methods:

A study of 30-day readmissions and ED revisits following discharge from a tertiary hospital to SNFs was conducted from April

through June 2025. Acute transfers from SNFs back to the index hospital were identified daily using the Epic SlicerDicer tool for real-time analysis. Two experienced SNF clinicians independently reviewed each case to assess the primary contributing factors, potential preventability, and possible interventions. Data sources included index admission notes, discharge summaries, ED documentation, and readmission histories.

Results:

Of 1,232 SNF discharges, 183 cases (14.9%) from 35 SNFs returned to acute care at the index hospital within 30 days—comprising 131 hospital readmissions (71.6%), 52 ED revisits (27.9%), and 1 ED observation (0.5%). The primary contributing factors were: medical complexity (39.3%), lack of SNF resources (24.0%), inadequate management of acute medical conditions at SNF (18.0%), unnecessary ED transfers (13.7%), and inadequate goals of care planning (12.0%). Notably, 71 cases (38.8%) were deemed potentially preventable by both reviewers. Among these, the most frequently cited potential interventions were: targeted education for SNF staff on managing common conditions (33.8%); a tele-ED program to enable on-site management and reduce unnecessary transfers (32.4%); protocols for prompt identification and management of patient condition changes at SNFs before sending to the ED (31.0%); and enhanced discharge documentation (18.3%).

Conclusions:

Nearly 40% of SNF readmissions and ED revisits are potentially preventable; opportunities for improvement center on enhanced communication among SNF and hospital providers during transitions and moments of crisis. These findings will guide quality initiatives to reduce avoidable readmissions and ensure better care continuity for SNF residents transitioning from hospital to post-acute settings.

B193

Structured Psychotropic Medication Review Process for Long-Term Care Residents

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Background About 80% of residents residing in long-term care facilities are prescribed at least one psychotropic medication (1). Overuse of these medications increases risk of falls and cognitive decline. Latest CMS regulations (F605) mandates attempting two gradual dose reductions (GDR) twice in separate quarters with patient consent to promote non-pharmacologic interventions and reduce adverse side effects (2). This study aims to develop a structured psychotropic review process coupled with physician regulatory visits for long-term care residents to improve patient safety and meet CMS regulations.

Methods A chart review was performed on 80 long-term care residents who were prescribed a psychotropic medication (antidepressant, anxiolytic, antipsychotic, hypnotic) to assess their indication for use. An interdisciplinary team of physicians, pharmacists, and behavioral health specialists met monthly to review each resident's care plan and assess behavioral concerns while concurrently completing this comprehensive evaluation prior to a GDR attempt. The patients' first review was scheduled with their 60-day visit and the second review was scheduled with their 7-month visit.

Results The chart review identified the psychotropic medication targets for patient medication adjustments. This allowed for scheduling of the physician visit to concurrently occur with preceding knowledge of potential dose adjustment considerations of psychotropics. The primary outcome was completion of the 160 chart reviews at the 60-day visit and 7-month visit satisfying the CMS regulation of a twice-yearly review. The secondary patient centered outcome was gradual dose reduction attempts and deprescribing.

Conclusions Long-term care residents are at high risk for unnecessary use of psychotropic medications. Developing a multi-disciplinary structured medication review process coupled with a physician visit prior to performing a GDR will prioritize patient safety, promote deprescribing and meet CMS regulations.

B194 Student Presentation

Bridging Generations: Reducing Loneliness Through Resident-Centered Activities in Nursing Homes

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Background:

Loneliness and social isolation are common among nursing home residents and are associated with depression, cognitive decline, and reduced quality of life. Intergenerational programs offer a promising way to enhance well-being by fostering meaningful interaction between youth and older adults. This student-led quality improvement project evaluated the impact of resident-centered activities involving volunteers on loneliness with preliminary findings guiding ongoing program refinement.

Methods:

Structured intergenerational sessions including board games, card games, and simple art activities, were implemented at a nursing home in Los Angeles, California. Participating residents completed pre- and post-session surveys assessing activity enjoyment and loneliness using items adapted from the UCLA Loneliness Scale, rated on a 5-point Likert scale. Facilitators also documented qualitative observations and reflections. Paired t-tests compared mean pre- and post-survey scores, and qualitative notes were reviewed for major themes.

Results:

Residents (n=38) strongly preferred low-tech activities, specifically board and card games (71%) over puzzles (21%) and digital games (8%). Mean enjoyment scores increased from 2.3 (SD 0.7) to 3.7 (SD 0.9) on a 5-point scale, indicating greater satisfaction with intergenerational activities (p<0.01). Across the three UCLA loneliness items, residents showed modest improvements, including reduced lack of companionship (mean difference -0.4), feeling left out (mean difference -0.2), and feeling isolated (mean difference -0.3) (p<0.01 for each). Mean composite scores decreased from 6.2 (SD 0.6) to 5.4 (SD 0.6), indicating reduction in perceived loneliness (p<0.01). Themes included enhanced companionship, nostalgia, and a renewed sense of belonging, while volunteers reported greater empathy, patience, and appreciation for older adults.

Conclusions:

Findings suggest that low-tech activities promote enjoyment, enhance social connection and reduce feelings of loneliness among older adults while cultivating empathy in youth volunteers. Ongoing Plan-Do-Study-Act cycles will focus on refining survey questionnaires, expanding participation to more older adults and facilities, and strengthening sustained engagement. Developing a structured toolkit may serve as a next step to support consistent implementation and training for future intergenerational activity programs.

B195 Resident Presentation

Implementing 4Ms Assessment using the Annual Wellness Visit Model in the Adult Primary Care Clinic of a Public Safety-Net Hospital

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Background:

Bellevue Hospital is the flagship of NYC Health + Hospitals (H+H), the largest public health system in the U.S., which includes 11 hospitals and over 60 outpatient clinics. The Bellevue Adult Primary Care Clinic (APCC) has around 5000 patients over the age of 65, many with socio-economic needs that are common to safety-net institutions. To address these needs and improve the quality of geriatric care, the Centers for Medicare & Medicaid Services (CMS) introduced the Annual Wellness Visit (AWV).

Methods:

In April 2024, we implemented AWVs in the Bellevue APCC, focusing on the Age-Friendly Health Systems (AFHS) 4Ms —What

Matters, Medication, Mentation, and Mobility. Patient care associates (PCAs) and registered nurses (RNs) completed geriatric screenings, which were reviewed by the patients' primary care physicians (PCPs). A standardized AWV smartphrase in the electronic medical record (EMR) brought screening results directly into the PCP's encounter note, allowing for easy identification of patient needs. We used a combination of virtual group and individual training sessions to train all staff. We surveyed PCPs, RNs, and PCAs immediately post training and six months after implementation on their confidence in performing AWV and the perceived impact on patient care, using a 5-point Likert scale.

Results:

Between April and December 2024, we trained 90% of PCPs (27/30), 100% of RNs (8/8) and 100% of PCAs (21/21). 552 AWVs were completed, all including the 4Ms assessment. Mean post-training confidence levels on a 5-point scale, 1 (lowest) and 5 (highest), were 4.5 for PCPs, 3.5 for RNs, and 4.0 for PCAs. At 6 months, confidence was stable for PCPs (4.4), and improved for RNs (4.8) and PCAs (4.5). Mean perceived impact on patient care was high post-training: PCPs (4.7), RNs (4.3) and PCAs (4.5). This remained high at 6 months: PCPs (4.3), RNs (5.0) and PCAs (4.4).

Conclusion:

Embedding 4Ms within AWV in primary care in a safety-net health system is feasible, well-received by staff, and useful for addressing geriatric needs.

B196 Student Presentation

Association of entry-level workforce training with residents' oral health outcomes

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Background: Less than 10% of individuals with Alzheimer's disease and related disorders (ADRD) receive oral health care. Long-term care facilities staffing may not be prepared to provide oral health care. Even after the COVID-19 pandemic, long-term care facilities share administrative challenges of increased job turnover rates of entry-level workers, and this resulted in limited capacity of providing long-term care services.

Methods: In an urban Nevada Medicaid long-term care facility, job turnover rate of certified nursing assistants (CNAs) in 2023 was 44.2% (23/52). Registered apprenticeship program (RAP) for CNAs were implemented as 8:2 (work: training hours) over 6 month periods (7/1-12/31/2024). Curriculum was oro-systemic care prioritizing denture management, tooth brushing, and aspiration precaution in feeding. Outcomes were (1) oral health access to care; (2) hospital admission due to pneumonia before training, 1/1-6/30/2024 and after training, 1/1-6/30/2025 among individuals with ADRD. This quality improvement project was exempt for review by the University of Nevada, Las Vegas Institutional Review Board (#1613064-1).

Results: A total of 21 residents living with ADRD were participants. Age, mean ± standard deviation, was 81.1 ± 10.7. Thirteen residents were female (61.9%). Ten residents were non-Hispanic White (47.6%); 23.8% (5/21), Hispanic; 14.3% (3/21), Black; 9.6% (2/21), Asian/Pacific Islander; 4.7% (1/21), American Indian/Alaska Native. Eight residents were moderately or severely impaired status of cognitive function (38.0%). Oral health access to care improved from 14.3% (3/21) to 38.1% (8/21) ($\chi^2 = 5.5$, $P = .02$); Hospital admission due to pneumonia was lowered from 42.8% (9/21) to 14.3% (3/21) ($\chi^2 = 4.2$, $P = .04$).

Conclusion: This oro-systemic care model and entry-workforce training at long-term care facilities may play a pivotal role in mutually reinforcing positive outcomes for residents at long-term care facilities

by improving access to oral health care and reducing hospital admission; for entry workforce by advancing CNA career pathway through empowered clinical skills and followed by higher salaries; for employers by achieving better health outcomes along with entry-level job stability.

B197

Pre-visit Planning to Improve Hepatitis C Screening Rates in Assisted Living Facilities

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Background

Hepatitis C virus (HCV) affects 2% of the world's population. Hepatitis C infection in older adults has a more rapid progression, increasing the risk for liver disease and transplantation. Current USPSTF guidelines recommend screening adults aged 18 to 79. Despite having a 3-fold higher prevalence in long-term care compared to other settings, HCV screening in assisted living facilities (ALFs) has not been well studied. We aimed to use pre-visit planning to increase Hepatitis C screening to at least 60% of eligible patients enrolled in an ALF home care program over a 12-month period.

Methods

Inclusion criteria included: 1) patients ≤ 79 years old and 2) patients who had at least one visit between 1/01/25 to 12/31/25. Participants were excluded if they did not establish care between 9/01/23 to 8/31/24 or expired prior to 1/01/25. An HCV antibody order was placed in the electronic medical record (EMR). Patients/caregivers consented prior to labs being ordered. The primary outcome was the number of patients screened for HCV quarterly (i.e. Q2 was April to June). The secondary outcome was the number of patients who had an HCV lab ordered. When patients have labs drawn for other purposes, the ordered HCV antibody test will be collected, thus there may be a natural delay in capturing completed HCV testing. Results for Q4 will be completed by January 2026. Statistics were calculated via Excel RealStats and ANOVA testing will be performed.

Results

A total of 95 patients (mean age 74 ± 4 ; 72% women, 62% White, 21% Black) met inclusion criteria. At baseline, 25.3% of these patients were screened for HCV. During Q1, 16% of the patients were screened and 83.7% of patients had an HCV lab order placed. For Q2, 32% of the patients were screened and 89% had an order placed. For Q3, 53% of the patients were screened and 88% of patients had an order placed.

Conclusion

This QI project showed that pre-visit planning increased the HCV screening rates in those who resided in ALFs. Implementing pre-visit planning in other care sites where older patients receive care may help to increase HCV screening rates among older adults in all healthcare systems. Future research in this area will undoubtedly work to determine the impact of screening in this population.

B198

The status of 'bone health' in home bound older adults: challenges in screening and initiation of treatment

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Background: Falls have a devastating effect on the quality of life of home-bound older adults. In this population, fractures are a leading cause of morbidity, mortality, and loss of function. Studies highlight that osteoporosis (OP) is underdiagnosed and undertreated in older adults, especially those who are homebound. Here, we attempt to identify gaps in screening of OP and barriers in initiating treatment.

Method: A quality improvement project on OP screening and treatment was assembled by multiple PDSA cycles. Home bound patients who had fallen between April-July 2025 were included in

initial screening. We queried if patients who fell were treated with vitamin D or were referred to physical therapy. We queried if OP screening was performed using the FRAX score (in the absence of a recent DEXA scan), and if treatment was initiated. Since treatment rates were low, providers were surveyed in order to identify barriers in screening and treatment. **Results:** From April - July 2025, 100% of patients who had fallen were optimized with vitamin D and referred to physical therapy. Of those falls, 46% had history of prior fracture and 0% had a DEXA scan within 3 years. Screening with FRAX on admission was implemented in all patients admitted to the house call program. Consequently, the FRAX documentation increased from 15% in April to 93% in May and 100% in June. Despite optimizing FRAX screening, only 1 out of 13 patients in July 2025 with a high FRAX score were started on osteoporosis treatment. Providers of our house call program and other programs nationwide were surveyed to identify barriers in implementing treatment. Barriers included adherence, fall history, prior fracture, difficulty in using FRAX, lack of dental clearance, unclear exclusion criteria (bedbound, hospice, prognosis/life expectancy, functional status) and limited time during visit. **Conclusion:** Despite clear evidence and guidelines supporting osteoporosis treatment, home-bound individuals remain undertreated due to clinical, functional, and systemic barriers. Our study showed that patients are not always screened for OP, and FRAX is not routinely utilized in the absence of DEXA scan. This work supports the next step in improving OP screening and treatment by developing a tool that can save time and ambiguity for providers, while plans remain patient centered.

B199

Twelve years of QI curriculum development in geriatrics and palliative care fellowship: outcomes and lessons learned

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Introduction

Quality improvement (QI) education is vital in geriatrics and palliative care, where patient vulnerability and system complexity demand high-quality standards. Despite Accreditation Council for Graduate Medical Education (ACGME) requirements, structured longitudinal QI training in fellowships remains limited. We describe a 12-year development of a project-based QI curriculum using Kern's framework for curriculum development.

Method

From 2013 to 2024, our program implemented a 9-month, team-based QI curriculum. The curriculum evolved through multiple improvement cycles guided by fellow feedback and faculty development initiatives. Faculty mentors support projects as senior coaches. Fellows completed a pre and post curriculum survey, including 5-item questionnaire on comfort with QI concepts on a Likert Scale, 3 cases from the Quality Improvement Knowledge Application Tool (QIKAT), and an open-ended course evaluation and feedback.

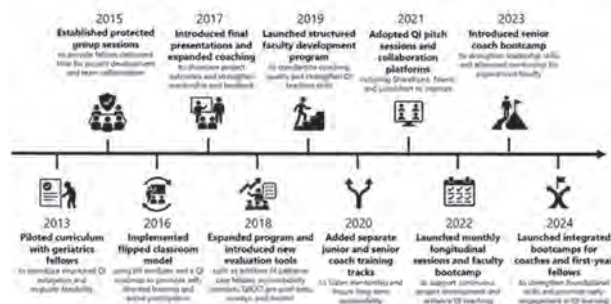
Results

Over 12 years, 282 fellows and 92 senior coaches completed 57 QI projects. Forty-eight projects were presented at national conferences. First year fellows demonstrated improved comfort with utilizing all 5 QI tools ($p < 0.001$) and improved QI knowledge (QIKAT Pre 20.4, Post 22.9; $p < 0.002$). Common curriculum barriers included limited protected time, variable engagement, and difficulty completing Plan-Do-Study-Act cycles. As shown in the Figure, multiple curriculum changes were introduced to enhance fellow engagement, optimize project workflows, and reinforce mentorship by providing structured coaching and time-saving resources.

Conclusion

This 12-year experience demonstrates a sustainable framework adaptable to other fellowship programs aiming to strengthen QI education within competency-based training.

Development of QI curriculum timeline



B200

Implementation of a Low-Cost Medication Reminder System to Improve Blood Pressure Control in Older Adults

K. Johnson, J. James-Coutou, S. Hayan, A. Kazi, M. Chen, E. Johnston, S. Ajmal, E. Nemytova. *NYU Langone, New York City, NY.*

Background

Nearly half of U.S. adults live with hypertension (HTN), yet only one in four achieve a target blood pressure (BP) of <140/90. Approximately 70% of adults 65 years and older remain uncontrolled, facing ongoing risks of stroke and myocardial infarction. Although antihypertensive medications are essential, only half of older adults take them as prescribed. Low-cost reminder tools such as pillboxes may improve adherence. We aimed to improve BP control among older adults with uncontrolled HTN using a structured medication reminder system that combined a pillbox and an alarm, supported by nurse visits.

Methods

We identified patients ≥ 65 years old during routine visits in our safety-net clinic if they used antihypertensive medication, self-managed their pills and had a BP $>140/90$ mmHg. We provided eligible participants with a pillbox and alarm, programmed to match each patient's preferred medication time. Participants filled their pillboxes with prescribed medications and attended nursing visits twice monthly for BP monitoring [CJ1] until their readings consistently fell below 140/90 mmHg. Nursing staff documented pillbox and alarm use at each visit, reinforcing adherence and adjusting alarm times if needed.

Results

Thirty-six older adults were enrolled (mean age 79 years, 72% female). Mean baseline SBP/DBP was 156/72 mmHg. Follow-up completion declined over time (63% at 2 weeks; 16% at 8 weeks). Among participants with paired measurements, SBP decreased by 17 mmHg at 2 weeks (n=23), 19 mmHg at 4 weeks (n=16), 20 mmHg at 6 weeks (n=9), and 18 mmHg at 8 weeks (n=3). DBP decreased by 3–15 mmHg across intervals. The intervention produced substantial early BP improvement despite high attrition.

Conclusion:

A structured medication reminder system that combined a pillbox and alarm improved adherence and BP control among older adults in a safety net outpatient geriatrics clinic. Whether BP control can be sustained without nurse visits requires further evaluation. This low-cost intervention may strengthen routine primary care efforts to enhance adherence and chronic disease outcomes in older adults.

B201

A Malnutrition Intervention for Older Adults in the Ambulatory Setting

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Background

Malnutrition is common but underrecognized in primary care among older adults. Nutrition interventions can improve weight and physical function, but systematic screening and targeted interventions are rarely integrated into primary care settings. We aimed to identify malnourished or at-risk older adults in a safety-net geriatrics clinic using the electronic health record (EHR) to implement a low-cost, structured intervention.

Methods

We used retrospective chart review to identify and contact clinic patients aged ≥ 65 years having a body mass index (BMI) <18.5 kg/m² or <22 kg/m² with $>5\%$ weight loss who were seen in the past 12 months. Patients with active malignancy were excluded. We screened patients by phone or during clinic visits, using the Mini Nutrition Assessment (MNA). Patients with, or at risk for, malnutrition based on MNA scores received counseling on food-first strategies emphasizing high protein, calorie-dense foods. Those meeting EHR-based insurance coverage criteria were prescribed oral nutrition supplements (ONS). We measured patient weight and BMI at 0, 3, and 6 months.

Results

A total of 63 patients were enrolled with mean age 82 (standard deviation (SD): 6.5; 67% female; 89% non-White). 79% were insured with dual coverage with Medicaid/Medicare, 15% Medicare only, and 5% were uninsured. The baseline mean MNA score was 6.5 (SD: 2.3) and mean enrollment BMI was 18.07 kg/m² (SD: 1.8). 57% of patients initiated ONS (n=31 prescribed, n=7 self-pay, n=0 home-made). Among 29 participants with complete 3-month follow-up, mean BMI increased from 17.58 kg/m² (SD 1.25) at enrollment to 17.76 kg/m² (SD 1.26) at 3 months. The mean BMI change was +0.18 kg/m² (SD 0.86), with median improvement of +0.30 kg/m². Overall, 62% (18/29) demonstrated BMI improvement, 34% (10/29) experienced decline, and 1 participant had no change.

Conclusion

A structured malnutrition intervention using EHR identification, food-first counseling, tailored ONS access, and routine weight monitoring helped to curtail unplanned weight loss among patients who returned for follow-up. These findings support integrating malnutrition screening and low-cost nutrition interventions into routine primary care for older adults.

B202 Resident Presentation

Evaluating the Outcomes of Pharmacist Referrals Among Older Veterans After an Emergency Department Visit

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Background

Pharmacy needs are often high among older adults presenting to the Emergency Department (ED) due to challenges regarding medication management. While pharmacists play a crucial role in addressing these needs, a standardized approach to geriatric ED pharmacy care has not been fully developed. The purpose of this study is to describe geriatric pharmacy needs and evaluate the post-ED interventions performed by a pharmacist among older adults presenting to the ED.

Methods

This retrospective quality improvement study reviewed medical records to describe a sample of older Veterans (aged 65+ years) seen by a geriatric pharmacist between 9/1/24-9/30/25. Veterans were

included if they screened positive on an in-ED pharmacy screen evaluating for polypharmacy, adherence concerns, and potentially inappropriate medications. They were then referred to and completed a post-ED visit with a geriatric Clinical Pharmacist Practitioner (CPP). Outcomes included reason for the pharmacy consult, time from the ED visit to the pharmacy visit, and the CPP's recommendations and interventions. Data were analyzed using descriptive statistics.

Results

The sample (n=36) was primarily male (88.9%) with a mean (SD) age of 77.5 (7.9) years (range 65–101). The most common referral to the geriatric pharmacist was for polypharmacy (64%) followed by adherence concerns (58%) and potentially inappropriate medications (25%). The average time (SD) from the ED visit to the pharmacy visit was 11.4 (5.9) days. The most common pharmacy recommendations were to discuss alignment of medications and goals of care (19%), order labs (8%), and discontinue potentially inappropriate medications (8%). The most frequent pharmacy interventions were medication reconciliation (75%), medication counseling (56%), care coordination (47%), and changing to easy-open caps (33%). All pharmacy interventions and recommendations were addressed for the majority of Veterans (86%).

Conclusion

Older adults presenting to the ED have pharmacy needs that can be addressed by post-ED pharmacist interventions. Models of care are needed to promote ED identification of pharmacy needs and referral to pharmacists to increase access to care and improve overall medication management for older adults.

B203 Resident Presentation

Antipsychotic Deprescribing at Discharge in Older Adults

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BACKGROUND:

The American Geriatric Society and American Psychiatric Association recommend non-pharmacological interventions to manage delirium, using antipsychotic medications (APM) only at the lowest dose for the shortest duration. Inappropriate APM use risks adverse drug events in older adults such as arrhythmias, extrapyramidal symptoms, metabolic disorders, neuroleptic malignant syndrome, and increased risk of mortality in dementia patients. APMs are often inappropriately prescribed at discharge without a follow-up plan. The purpose of this study was to evaluate the impact of pharmacist-led deprescribing on inappropriate APM use in older adults on discharge.

METHODS:

This institutional review board-approved, quasi-experimental study at a community teaching hospital included patients aged 65 years and older with a consult to the geriatric service for agitation, altered mental status, or delirium, and an APM ordered for management. A pharmacist-developed job aide on inappropriate APM use was sent to providers. A pharmacist investigator reviewed current patient charts for deprescribing opportunities and contacted the provider for a joint APM use decision. Primary outcome was the incidence of inappropriate APM prescription at discharge, defined as use without first optimizing non-APM modalities of de-escalation, reorientation, and addressing contributing factors or if the patient was not significantly distressed to risk harm to self or others. Secondary outcomes assessed if the APM was discontinued by a pharmacist, days of APM therapy, and length of stay. Outcomes were analyzed via chi-square test and descriptive statistics.

RESULTS:

Sixty-seven patients were included in the pre-implementation phase (average age 86 years, 53.7% female). The average duration of APM therapy was 2.6 days, and 37.3% of patients were prescribed an APM at discharge. Of those, 56% (14) were deemed inappropriate, 8%

of whom had a documented follow-up plan. Post-implementation, four patients have been included of 23 evaluated (average age 83 years, 50% female). The average length of APM therapy has been 1 day, and 1 patient (100%) was prescribed an APM at discharge, deemed inappropriate, with a documented follow-up plan.

CONCLUSIONS:

Inappropriate APM use was lower in the post-implementation group and documented follow-up plans increased, showing potential benefit of pharmacist-led deprescribing in older adults.

B204 Resident Presentation

Patient-Directed Education with Pharmacist Outreach to Promote Proton Pump Inhibitor (PPI) Deprescribing in Older Adults

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Background: Proton Pump Inhibitors (PPIs) are commonly prescribed medications for upper gastrointestinal disorders, yet 70% of patients taking a PPI lack a clear indication for use. Effective strategies to increase deprescribing include patient-directed education and pharmacist-led interventions including direct patient outreach.¹⁻³ However, the combined intervention of patient-directed education and pharmacist outreach for PPI deprescribing has not previously been explored. This study aimed to quantify PPI deprescribing rates after a patient-directed education and pharmacist outreach intervention in older adults.

Methods: This prospective cohort study was conducted at two outpatient geriatric primary care clinics. Patients included in the study were community-dwelling patients ≥ 65 years of age seen at one of the clinics within the last year for primary care and taking a prescribed PPI. Patients with an indication for continued PPI therapy were excluded. Patients in the intervention group received a patient-directed educational brochure on PPI deprescribing and a phone call from a pharmacist ahead of their PCP appointment. Patients in the control group received the current standard of care. The primary outcome was PPI deprescribing measured at the end of an 8-week period. Secondary outcomes included utilization of histamine-2 receptor antagonists and incidence of gastrointestinal bleeding. Study data was analyzed using basic statistical measures.

Results: 86 patients across both clinics took a prescribed PPI. Of this population, 44 patients did not have a compelling indication for PPI continuation. Baseline characteristics were similar between the intervention (n=17, mean age 79, 82% female) and control (n=27, mean age 81, 85% female) groups, with most patients taking ≥ 5 medications at baseline. The mean duration of PPI use in both groups was 9 years, with ≤ 15% of patients with a prior deprescribing attempt. We expect patients who receive the patient-directed education and pharmacist outreach will achieve higher rates of PPI deprescribing than the control group.

Conclusions: Pharmacists promote deprescribing PPIs in primary care through patient eligibility screenings, patient education, and direct outreach.

References:

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2. JAMA. 2018;320(18):1889-1898.
3. JAMA. 2024;184(11):1339-1346.

B205

Implementing the IHI Age-Friendly Initiative in a Safety-Net

Clinic: Universal Dementia Screening in Older Adults: QI Project

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Background: Safety-net populations have higher rates of dementia but lower screening and treatment rates. In 2021, California mandated annual Cognitive Health Assessments (CHA) for Medi-Cal (Medicaid) only beneficiaries aged >65 years old. The Los Angeles County Department of Health Services (DHS) participated in the

state-funded Dementia Care Aware pilot, which relied on providers to conduct CHAs. From 12/2022 through 9/2024, Clinical Informatics identified patients eligible for CHA based on these criteria: seen within one year, no preexisting dementia or mild/unspecified cognitive impairment, or prescription of dementia medications. The DHS clinics' baseline screening rate for dementia using the CHA was 16% by 8/2024. In our Geriatric Fellows' Clinic, the screening rate was 13% by 8/2024. Our goal was to improve the dementia screening rate at our clinic from 13% to >70% by 12/2025.

Methods: We analysed CHA completion rates between 8/2024 and 8/2025 at Harbor-UCLA Medical Center's Geriatrics Fellows' Clinic. Using the Lean PDSA protocol, a Gemba walk and process mapping were performed to identify root causes and develop countermeasures to improve the screening rate.

Results: Overall, 67% of patients were Hispanic/Latinx, 52% preferred English, and 45% preferred Spanish. The baseline CHA completion rate was 13% in 8/2024. By using the Gemba Walk and root cause analysis, it was found that the lower screening rates were due to providers not completing the CHA due to several factors: competing priorities, the CHA form not being in the room, and completed forms not being scanned. To address this root cause, the CHA screening was transitioned to the nursing intake workflow in the EHR starting in 5/2025. Remeasured screening rate in the fellows' clinic demonstrated an increased screening rate from 19.4% in 2/2025 to 92% in 8/2025. Reasons for incomplete screenings include providers not being alerted in a timely manner about positive CHA screening and/or competing interests during visits.

Conclusions: In a safety net geriatrics clinic, dementia screening rates significantly improved when a systematic team-based approach was implemented. Future steps include establishing nursing protocols to alert providers when a patient has an abnormal CHA and assessing outcomes of positive screening.

B206 Student Presentation **Preoperative Nutrition and Exercise Counseling for Older Adults Experiencing Frailty**

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Background: Frailty among older adults greatly increases post-operative risk, making surgical prehabilitation for frailty a priority. Malnutrition and weakness are dimensions of the frailty syndrome that may be addressed in the short time frame between the first preoperative visit and surgery. While the OHSU Preoperative Medicine Clinic (PMC) has established protocols for assessing frailty in geriatric patients, we have not previously acted on a diagnosis of frailty through direct patient counseling. Our goal is to impact postoperative outcomes for frail patients by improving their preoperative nutrition and strength using an evidence-based education strategy.

Methods: We created an Epic SmartPhrase for prehabilitation targeting frail older adults which provided recommendations regarding high-protein dietary sources, exercise modalities, and nutritional supplementation to support preoperative muscle and strength optimization. PMC clinicians received written and in-person training on the tool. We tracked utilization for six weeks and gathered survey data on perceived knowledge/confidence following the presentation.

Results: The SmartPhrase was used 40 times by ten different PMC clinicians in the twelve weeks after it was introduced. Seven (44%) of the PMC clinicians completed a follow-up survey. Clinicians reported their knowledge about preoperative protein, resistance exercise, and muscle building increased after the training from 2.4 to 3.8 on a 5-point scale. They reported their confidence in counseling patients about nutrition prehabilitation increased from 2.4 to 3.4 on a 4-point scale.

Conclusions: Initial implementation with brief training improved providers' knowledge and confidence in counseling geriatric preoperative patients on nutrition and exercise. Further research is needed to assess patient perspectives and to generate more robust data to enhance preoperative care for older adults.

B207 Resident Presentation **Impact of Home-Based Primary Care Pharmacist Interventions Post-Hospitalization on Hospital Readmissions**

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Background:

Home-Based Primary Care (HBPC) provides interdisciplinary care to medically, socially, and functionally complex Veterans who cannot access clinic-based services. HBPC is evaluated using hospital-centered metrics such as 30-day readmissions. A quality improvement (QI) project assessed whether clinical pharmacist practitioner (CPP) home visits conducted 7–14 days post-discharge improved medication management and impacted readmission rates.

Methods:

This QI project included Veterans in the Seguin HBPC team who received CPP post-discharge visits from 2023–2025. Data from chart review included demographics, clinical risk scores (CAN, Nosos, JFI), hospitalization details, readmission specifics, and care coordination indicators (provider notification, caregiver support, medication organizer use, adherence documentation, and timing of visit). CPP interventions related to medications were also assessed. The primary outcome was 30-day readmission. Trends were analyzed using descriptive statistics.

Results:

Twenty four patients were included (12 in each arm). Thirty-day readmissions were higher in the pilot group (mean 33.3% vs 8.3%), majority with the initial presentation symptoms. Pilot patients demonstrated higher clinical complexity and were more frail, reflected by higher mean CAN scores (95.38 vs 94.5), Nosos scores (4.48 vs 4.07), JFI scores (9.17 vs 7.33), and longer lengths of stay (17.67 vs 8.08 days). CPP visits occurred later after discharge (7 vs 4.5 days) but resulted in substantially more total medication interventions (26 vs 4), including reconciliation and regimen adjustments. Medication compliance was 81.81% (n = 11) vs 62.5% (n = 8) for those with documentation. Findings are limited by small sample size, documentation gaps, and unmeasured confounders.

Conclusions:

CPP home visits improved medication management and patient education but did not reduce 30-day readmissions in this small cohort. Findings will be presented to the HBPC team to support performance improvements with a collaborative focus on improving documentation, enhancing medication reconciliation, obtaining accurate external hospitalization records, and closer CPP follow-up post-discharge.

B208 **Bridging the Gap: Standardizing Preoperative Geriatric Assessment in Real-World Practice**

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Background:

Preoperative assessments for older adults remain variable, despite evidence that Comprehensive Geriatric Assessment prior to surgery improves outcomes (1). A quality improvement (QI) project was initiated to standardize preoperative assessments for older adults. Operational and systems-level challenges that emerged during implementation are highlighted.

Methods:

Using QI methodology, we developed a process map to understand current preoperative workflow and identified barriers to incorporating geriatric assessments in ambulatory settings. Data on referral patterns, consult completion rates, and template utilization were reviewed and analyzed. Root cause analysis informed the prioritization of challenges to address.

Results:

Four implementation challenges emerged: (1) electronic medical records (EMR) limitations, no referral option, or standardized criteria for geriatric preoperative evaluation; (2) workflow barriers, difficulty scheduling visits, and inconsistent appointment lengths; (3) limited specialty engagement, low awareness of geriatrics' perioperative role; and (4) inconsistent template use among providers. In response, a dedicated EMR referral order set and consult visit type were created, surgical specialties were engaged to develop a referral algorithm, and education and clinic-based reminders were introduced to improve consistent use of the geriatrics assessment template.

Conclusion:

Implementation of standardized preoperative geriatrics assessments in real-world clinical settings presents challenges across technological, clinical, and administrative domains, creating opportunities to embed geriatric principles into surgical practice, enhance EMR functionality, streamline workflows, and improve interdepartmental coordination. Continued QI work and interdisciplinary collaboration are needed to improve perioperative care for older adults.

References

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B209

Improving Guardianship Processes in Colorado: A Needs Assessment

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Background

The guardianship system aims to protect vulnerable individuals who cannot make decisions for themselves; however, it is an imprecise tool that removes a person's full civil rights. The process of obtaining guardianship is complex and involves multiple stakeholders. These system complexities, along with differing perspectives on balancing autonomy and safety, can lead to communication challenges and care delays for adults needing guardianship. We are conducting a needs assessment survey of relevant stakeholders across Colorado to inform future interventions to improve the guardianship process in the state.

Methods

Survey questions were developed after interviews with select stakeholders. Questions include open-ended and Likert-scale formats; some questions are specific to participant roles. The survey was distributed via Qualtrics to relevant parties including guardians, Adult Protective Service (APS) workers, attorneys, judges, community advocates, medical providers, law enforcement officials, healthcare administrators, and policymakers. Snowball sampling was used intentionally in order to reach a broad range of stakeholders. As a quality improvement project, the survey is IRB-exempt.

Results

134 participants across sectors have completed the survey as of November 2025. Participants work in multiple environments including urban (52%), suburban (43%), and rural (40%). Key areas identified that should not be changed about the guardianship process include oversight by the courts with significant checks and balances, attempts to identify least restrictive alternatives and preserve the rights of people needing guardianship, medical documentation requirements,

and ability to obtain emergency guardianship. Key areas identified for improvement are more state funding for professional guardians, more training/resources for guardians, a centralized process in the state, inter-county collaboration, faster guardianship processes, and increased court oversight. The survey is still open with ongoing collection of data that will continue into 2026.

Conclusions

This needs assessment has identified several potential areas for improvement and reflects the tension of autonomy versus safety when pursuing guardianship. Results will be distributed to relevant stakeholders in Colorado, including through a convening of stakeholders in 2026 where data will be reviewed and interventions will be developed.

B210

Decreasing Falls in the Community Living Center (CLC)

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Background: Falls in long-term care facilities are common with estimates of 2-5 falls per resident /year. Morbidity with these falls is high with approximately 37% resulting in injury and 15.9% resulting in severe injury.

Our CLC experienced an increase in falls with major injury with two falls resulting in subdural hematoma and 1 resulting in a hip fracture over a twelve-month calendar year in 2023. Our multidisciplinary team sought to identify and decrease these injuries.

Methods: We used a multimodal approach to decrease falls with major injuries. First, we purchased whiteboards for every nursing unit and our last fall and last fall with major injury were tallied and discussed at each shift huddle. We also had a discussion of all the falls and days since the last injury in our morning leadership team meeting. Secondly, we implemented nursing education to reinforce safe patient handling and care for residents always using two staff members. This was done at in-services and is repeated annually at a Falls festival. Lastly, a Morse fall scale was done on each resident. We identified all veterans at high risk for falls using a cut-off of 45 and placed a falling star discreetly outside of their room to identify them for all staff. Since most of our residents are at high risk for falls, we wanted to identify and further delineate veterans at risk for falls of major injury. If veterans were on an anticoagulant, and at increased risk of having a subdural with a fall, we added a small blood drop to the star. If they also had a high risk for fracture determined by providers on every veteran using the Fracture Risk Assessment (FRAX) calculator, they also got a small bone. If veterans were determined at risk for both, they would have both a blood drop and a bone. This would easily identify from the hallway by visual inspection those at highest risk for major injuries.

Results:

- 0 falls with major injury in calendar year 2024 compared to 3 in 2023.
- Reduction in fall with major injury rate from 0.12 to 0.
- 451 consecutive days without a major injury at our CLC.

Conclusion:

Using a multimodal approach that further delineated those at risk for falls with major injury allowed us to significantly decrease the rate of major injuries to zero for 1 year.

B211

Improving Diabetes Treatment in a VA Community Living Center (CLC)

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Background:

Type 2 Diabetes Mellitus (DM) is common in older adults, especially in Post Acute Long Term Care (PALTC), leading to significant disease burden and cost. Sliding scale insulin (SSI) started in hospitals

often ends up being continued in PALTC, leading to higher injection burden, staff time, and unstable glucose control. Glycemic targets in PALTC residents are generally less stringent, with HbA1c goal aiming to minimize hypoglycemia and symptomatic hyperglycemia and maintain quality of life. The American Diabetes Association and PALTC Association guidelines support decreasing use of SSI and simplifying diabetes regimens in this setting.

We noticed a high use of SSI and fingersticks (FS) among our veterans with DM in the CLC, leading to high injection burden and staff time. Additionally, DM regimens were often not optimized to include newer guideline based therapies such as SGLT2 inhibitors, DPP-4 inhibitors, and GLP-1 inhibitors.

We aimed to improve the quality of diabetes care in the CLC by: Decreasing the use of SSI, decreasing the amount of FS to lower burden for veterans and staff and improve outcomes by adding newer medications when clinically indicated.

Methods:

We formed a task force of medical and pharmacy providers that met weekly. We used electronic medical platforms to monitor all CLC veterans on medications for DM and their labs. Education was given to CLC providers on strategies to decrease use of SSI and on newer medications for diabetes. We discussed how to best treat each veteran with decreasing FS and addition of new medications when indicated for comorbidities such as proteinuria and CHF.

Results:

Of the veterans being treated for DM in the CLC, 18 were deemed appropriate to assess during a 12 week period. If a veteran would not allow a change in their regimen or were not medically stable for DM management changes, they were excluded. Many of the 18 deemed appropriate to assess were discussed over multiple weeks with stepwise changes in their treatment. Of these veterans

- SSI was discontinued for 8 /18 (44%)
- Frequency of FS was decreased in 3 /18 (17%)
- New medications (Biguanides, SGLT2, DDP-4, GLP-1 agonists) were added in 10/18 (55%)

Conclusions: Meeting as a multidisciplinary team has allowed a decrease in the number and frequency of FS, which benefits veterans and staff. and optimized DM medications for veterans with other comorbidities such as CHF and CKD.

B212

Proactive and Targeted Geriatrics Deprescribing eConsults to Optimize Medications Among Older Adults in Primary Care

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Background: As a Learning Health System effort at UCSF, we developed a proactive deprescribing eConsult program staffed by geriatricians to assist primary care providers (PCPs) in deprescribing potentially inappropriate medications (PIMs). We launched a quality improvement pilot study to assess the feasibility and impact of deprescribing eConsults.

Methods: Using an EMR dashboard, we identified patients ≥ 65 years prescribed PIMs and with upcoming appointments. Integrating stakeholder feedback, we focused on patients taking ≥ 3 central nervous system (CNS) medications. We messaged participating PCPs to offer a deprescribing eConsult. If the PCP was interested and the patient provided consent, the study team completed the eConsult. We delivered prioritized deprescribing recommendations with suggested actions and information for patients/families. We conducted chart reviews of participating patients following eConsult delivery.

Results: From April 2025-October 2025, 10 PCPs participated, caring for 37 eligible patients. An additional 6 patients were identified, though no eConsult was offered as their CNS-active medications were exclusively managed by specialists.

Among eligible patients, 32% (12/37) agreed to the eConsult. The most frequent CNS-active medications were opioids, gabapentin, and sleep aids (e.g., trazodone, zolpidem). All PCPs (12/12) discussed polypharmacy and PIMs at the next appointment. Medication changes from eConsult recommendations were made at 75% (9/12) follow-up visits. One-third (3/9) involved dose reduction, 33% (3/9) involved discontinuing a medication and transitioning to a safer alternative, and 33% (3/9) involved discontinuing the medication. Two patients (17%, 2/12) declined medication changes.

Of the remaining eligible patients, 28% (7/25) declined the eConsult when offered by their PCP. Eight percent (2/25) were nearing hospice level of care and deemed not appropriate by their PCP. We did not receive explanations for why the eConsult was declined for the other 16 patients.

Conclusions: Proactive and targeted eConsults completed by geriatricians may assist non-geriatrician PCPs with deprescribing PIMs, particularly among PCPs and patients who are amenable to the intervention.

B213

QI Montessori-Based Dementia Training for LTC Volunteers

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Background

Rising prevalence of dementia and the growing older adult population intensify long-standing workforce shortages in long-term care, limiting quality person-centered interactions with residents. Montessori-based activity programming demonstrates potential to improve cognitive, behavioral, and affective outcomes for those living with dementia. The ENGAGE program was developed to introduce structured Montessori-based activity kits to support volunteers and staff in the provision of engaging and meaningful interactions with long-term memory care residents.

Methods

Volunteers of a residential memory care facility were recruited to participate. To evaluate feasibility and effect of Montessori-based training on volunteers' knowledge, comfort, and confidence while using the kits, training sessions were held that provided education on dementia, Montessori principles, communication strategies, and hands-on practice. Participants completed a five-item Likert-scale questionnaire before training and after a three-week implementation period to include at least two resident interactions using the kits. Perceived resident engagement, enjoyment, and usefulness were added to the post-uestionnaire. Data were collected anonymously without PHI access.

Results

Five volunteers completed pre- and post-training questionnaires. Mean scores increased across all five measured domains, including dementia knowledge, communication strategies, Montessori familiarity, and comfort and confidence working with memory care residents. Statistically significant improvements were observed in knowledge of memory impairment ($Z = -2.24$, $p = .025$) and confidence engaging residents ($Z = -2.24$, $p = .025$). The remaining domains demonstrated upward trends. Four of five volunteers completed the required resident interactions during the three-week implementation period.

Conclusions

A short-format, person-centered, Montessori-based training intervention improved volunteers' knowledge and comfort in engaging residents with dementia, demonstrating feasibility and potential positive impact of this low-cost strategy. It may also serve as a model for low-disruption adoption of these engagement strategies by short-staffed clinicians striving to optimize use of an already limited economy of time. Future work should include larger and more diverse samples, mixed-method design, evaluation of resident-level effects, and culture change.

B214

Implementing Hearing Screening Across Two Greater Los Angeles VA Geriatrics Clinics

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Background:

Hearing loss is common in older adults and linked to isolation, depression, and cognitive decline, yet is often unrecognized in primary and geriatric care settings. Although screening is required during the Medicare Annual Wellness Visit, there is no national quality of care measure, and the USPSTF cites insufficient evidence for routine population screening. A baseline review across two VA geriatrics clinics showed inconsistent documentation. We launched a QI initiative to increase screening using a standardized tool, the Hearing Handicap Inventory for the Elderly-Screening (HHIE-S), with the goal of increasing screening to 50% by June 2026 from less than 5% in September 2025.

Methods:

Using a PDSA cycle, the HHIE-S tool was integrated into the workflow of two VA geriatrics clinics. Pre-implementation workplace observations of clinic rooming and intake identified opportunities to embed screening. Plan: We added an HHIE-S section to the geriatrics note template in the EHR and educated fellows, nurses, and attendings on the screening tool and workflow. Do: The screening process was piloted for three months. Study: We monitored the percentage of visits with documented HHIE-S screening and collected feedback, supplemented by additional observations to identify barriers. Act: Based on feedback and workflow observations, we refined the template and clarified steps before expanding screening to rotating residents and medical students.

Results:

Baseline hearing screening completion was 2.9% for the previous three months. After implementation of the standardized workflow, screening rates increased to 73.8%. 42 patients were eligible for screening (average age 83.9 years, 9.8% female, 78.6% with MCI or MNCD). 28.6% were referred to audiology for initial hearing evaluation.

Conclusions:

This project addresses a key gap in preventive care and shows a practical approach to improving hearing-loss identification in geriatrics clinics without formal quality metrics. A standardized workflow across two sites markedly improved screening rates within three months. Integrating structured tools, staff education, and EHR prompts enhanced detection of potential hearing loss with minimal clinic burden. Next steps include sustaining improvements, expanding to additional clinics, and strengthening referral pathways.

B215

Implementing a patient-held “Polypharmacy Passport” to support deprescribing across inpatient and outpatient care: a single-center quality improvement study

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Background:

Potentially inappropriate medications (PIMs), fragmented lists and handoffs across care transitions increase risk of adverse events in older adults. We implemented a patient-held, wallet-sized “Polypharmacy Passport,” integrated with an electronic health record (EHR) workflow, to standardize medication reconciliation and deprescribing across inpatient and outpatient settings. We evaluated its impact on PIM burden and documentation quality.

Methods:

Prospective quality improvement study at a single academic health system (July–November 2025). Adults ≥ 65 years with ≥ 5 medications seen on a geriatrics-affiliated inpatient service or geriatrics clinic were eligible. A geriatrician–pharmacist team performed structured review using the 2023 AGS Beers Criteria, documented recommendations via a standardized EHR dot phrase, and issued a 4×6 Polypharmacy Passport listing active medications, PIM status, and deprescribing plans for use at discharge and subsequent visits. Primary outcome: change in number of PIMs from index review to 30 days. Secondary outcomes: change in total medication count, presence of a reconciled list in the EHR, and passport availability at follow-up. Descriptive statistics were used.

Results:

N=34; mean age 78 (SD 7); 60% women; 40% from historically excluded racial/ethnic groups. Median medications decreased from 14 (IQR 11–17) at index to 12 (IQR 9–15) at 30 days (14% relative reduction). At least one PIM was present in 27/34 (79%) at baseline vs 15/34 (44%) at 30 days; total PIMs decreased from 65 to 36 (45% reduction). A reconciled medication list in the EHR was documented post-implementation for 34/34 (100%) vs ~55% in historical controls. The Polypharmacy Passport was available and referenced at discharge or clinic follow-up for 29/34 (85%); 88% of responding clinicians and 89% of patients/caregivers reported improved regimen clarity and communication. No deprescribing-related adverse events were reported.

Conclusions:

A patient-held Polypharmacy Passport embedded in inpatient and outpatient workflows was feasible, improved documentation, and was associated with clinically meaningful reductions in PIM burden in this pilot. This low-cost, scalable tool supports safer prescribing across care transitions and merits evaluation in larger, more diverse populations.

B216

Barriers to Frailty Assessment: A Needs Assessment & Pilot

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Frailty assessments (FAs) identify vulnerability and aid in developing care plans, but routine implementation remains limited. Research indicates limited time and lack of specific knowledge and skills as barriers to conducting FAs. Digital resources that guide selection of FA tools, automate scoring and facilitate interpretation may make FA more efficient and accessible.

This QI work includes a needs assessment and pilot of 2 FA tools: 1) eFrailty.org, which provides guidance on selecting FAs and 2) VA GOAL, a secure interface that uses VA health data to calculate a claims-based electronic frailty index (eFI). The goal of this work is to understand barriers to FA, share knowledge about clinical innovations in FA and gather user feedback.

Methods: An electronic survey was sent to a convenience sample of physicians at VA Boston and Bedford in Aug. 2025. Data was analyzed using Microsoft Forms. Participants were invited to an educational session introducing VA GOAL and eFrailty.org and later to a semi-structured interview to provide feedback on their experiences.

Results: Survey response rate: 82% (14/17). 57% reported high confidence in administering FAs; however, several reported conducting FAs infrequently and 21% reported not conducting FAs at all. Among those who conduct FAs, 82% reported assessing frailty in <20% of encounters.

93% were familiar with eFrailty.org and 36% reported being regular users. 57% were familiar with VA-GOAL, but none considered themselves regular users. Several barriers were identified: time constraints, lack of collateral information, lack of support staff, perception of limited clinical utility, and uncertainty about which tool to use.

The pilot phase of the project is ongoing; 10 physicians completed the online educational session and 4 participated in semi-structured interviews.

Conclusions: Our findings suggest the challenge in improving rates of FA is not training, awareness, or tool availability, but rather implementation barriers. Electronic assessment tools may reduce time but remain underutilized. Future stages of this project hope to gain insight into why. As new electronic tools are developed to facilitate FA, this study highlights a transition in barriers from lack of knowledge and tools toward challenges in workflow integration and time efficiency. Addressing implementation gaps will be essential to achieve consistent FA in outpatient care.

B217

Improving Follow-Up After Fall Risk Screening: A Quality Improvement Initiative in Primary Care after the Medicare Annual Wellness Visit

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Background: Falls are a leading cause of preventable injury and disability among older adults. Although fall risk screening is routine in the Medicare Annual Wellness Visit (AWV), timely follow-up after a positive screen is often lacking. We implemented a primary care-based quality improvement initiative to increase the rate of fall risk prevention interventions provided to older adults at elevated fall risk.

Methods: We conducted a retrospective study of patients aged ≥ 65 years who completed an AWV between September 2024-October 2025 and screened positive for fall risk using a three-item screener and confirmed with an abnormal Timed Up and Go (TUG) test. On January 1, 2025, we implemented two quality improvement interventions for post-screening follow-up; (1) we implemented a SmartSet in the Electronic Health Record which guides clinicians to select a clinically appropriate follow-up after a positive fall risk screen, and (2) the geriatrics clinic proactively reached out to eligible patients to schedule comprehensive fall assessments. We evaluated follow-up rates over time. Outcomes measured 120 days post-screening during the AWV included: (1) the proportion of patients ≥ 65 with any documented follow-up action post-screening (physical therapy referral, case management visit, geriatrics referral, or geriatrics clinic visit) and (2) any geriatrics clinic visit.

Results: Among 2,524 patients completing an AWV, 1,213 received TUG screening, and 356 (29%) screened at high fall risk. Among patients screening positive for high fall risk, any follow-up increased from 48% pre-intervention (46/95) to 68% post-intervention (177/261). Follow-up geriatrics clinic visits increased from 5.3% to 42%. Primary care referral rates to geriatrics remained stable (5.3% to 5.0%), suggesting that the proactive outreach phone call drove the increased geriatric follow-ups.

Conclusion: A structured proactive initiative embedded in primary care significantly improved follow-up rates after positive fall risk screening among older adults.

B218 Encore Presentation

Early Evaluation of the ACE-T-N Nursing-Based Delirium Treatment Tool: A Multicenter Pilot Quality Improvement Project

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Background

Studies show variability in clinical team responses following a delirium diagnosis. Deficiencies include systematically identifying triggers, detecting and managing distress, and communicating the diagnosis. We developed the ACE-T-N tool (Acute Triggers / Patient Experience / Treatments - Nursing) to standardize nurse-led initial management. This pilot study reports a preliminary evaluation of the tool by clinical staff and a baseline assessment of delirium care quality in three centers (Stanford, Edinburgh, and Frankfurt).

Methods

The ACE-T-N staff evaluation comprised three components: (1) preliminary informal feedback from nurses and physicians; (2) a structured survey of nurses, physicians, and advanced practice providers assessing the tool's clarity, usability, and perceived value; and (3) a pre-intervention retrospective chart review of 30 patient records (10 per center) examining delirium care actions within 48 hours following formal diagnosis.

Results

Informal feedback on the ACE-T-N was largely favorable, particularly regarding the need for structured nursing guidance in delirium care. Among 53 survey respondents (50% nurses), more than 70% rated the tool as easy/very easy to use, with clear/very clear instructions, very/extremely helpful for guiding initial assessment, and very/extremely helpful for improving delirium management. Baseline chart review (prior to implementation) identified substantial documentation gaps in essential care practices, including distress assessment (46.7%), pain assessment (50%), and communication with patients or families (56.7%).

Conclusion

The ACE-T-N tool received positive feedback across disciplines at all three centers, with several useful suggestions for improvement. A revised version will undergo further testing. Baseline quality assessment revealed multiple deficiencies in documented care during the 48 hours following diagnosis. It also highlighted challenges in capturing delirium care responses, informing process refinement.

B219

Improving Annual Wellness Visit Completion Rates and Value: A Win All Around

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Background

Medicare Annual Wellness Visits (AWV) are a benefit designed to help providers develop a personalized preventive care plan for patients. They also provide an opportunity to implement age-friendly care at a regular interval. Their high reimbursement rate in value-based care arrangements incentivizes health systems to encourage providers to complete these visits. Yet, AWV completion rates remain low. Furthermore, inclusion of age-friendly 4Ms measures in the visits is not standardized, leading some patients and providers to question their benefit. Medicare Advantage plans contract with third parties to complete the AWV translating into potential lost revenue for providers

or health systems. Increasing Medicare AWW uptake and value is critical for meeting quality metrics and advancing age-friendly care.

Methods

We sought to increase office AWW completion rates and their perceived value by including 4Ms measures in the AWW and implementing a clinic outreach program. Patients due for an AWW attributed to a specific value-based contract were included. Nurse care managers:

1. Generated a list of eligible patients using EHR data.
2. Utilized the EHR novel age-friendly 4Ms dashboard to determine which 4Ms had been addressed within the previous year.
3. Incorporated 4Ms results into the AWW template.
4. Contacted patients via phone and electronic messaging to schedule AWWs.

AWW completion rates for patients attributed to the specific value-based contract for a two-month period after the intervention were compared to completion rates among the same providers for patients in the same value-based contract for the same two-month period one and two years prior to the intervention.

Results

AWW completion rates increased compared to baseline following the intervention. Payments increased by 176% between 2024 and 2025. Age-Friendly 4Ms measures were captured in all AWWs completed.

Conclusions

Clinic outreach supported by nurse care manager review significantly improved AWW completion rates in a value-based care population. Integrating the 4Ms framework into outreach workflows may further advance comprehensive, patient-centered care for older adults while also increasing revenue. This is a win-win-win for patients, providers, and health systems.

	# Visits Completed Oct and Nov			Payments for Oct and Nov			% Change after Intervention
	2023	2024	2025	2023	2024	2025	
AWW G0439	1	6	42	\$245.32	\$346.38	\$682.34	176%

B220

Efficiency and Quality of POLST Completion Upon Nursing Home Admission

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Background: The Physician Orders for Life-Sustaining Treatment (POLST) form documents a patient's wishes regarding code status and life-sustaining treatment and can effectively communicate the patient's preferences during a medical emergency. Incomplete or delayed POLST completion can lead to uncertainty and misalignment with patient goals. At our community nursing home in Los Angeles, California, the baseline POLST completion rate was 25% in October 2025. We aim to improve the completion rate to 60% by June 2026 through targeted nursing education.

Methods: Starting in September 2025, POLSTs of patients under the care of four geriatricians at a nursing facility were reviewed. Two skilled patient charts were randomly selected from each of the six nursing stations. Data collected included time from admission to date of patient/surrogate signature, care choices, and concordance between code status and treatment goals. Workflow observation and root cause analysis identified knowledge gaps among nursing staff and proper POLST completion. Physician-led training on POLST completion was given to nursing staff. The rate and quality of POLST completion after the intervention was measured again after the intervention.

Results: Out of the twelve pre-intervention POLSTs, two POLSTs were blank. Seven other POLSTs had incomplete sections, making nine of the POLSTs incomplete, resulting in an overall completion rate of 25%. None of the POLSTs were incongruent with code status and treatment goals. After the educational intervention, six POLSTs were analyzed, of which three (50%) were incomplete. Of these, one was blank, one was signed by the patient without treatment selections, one was missing a patient signature. All three of the

completed POLSTs were congruent, although one required physician correction for treatment preferences.

Conclusions: Focused nursing education may improve POLST completion and facilitate earlier correction of documentation inconsistencies. Continued education and monitoring are planned to increase completion rates and align POLST documentation with patient goals. Ongoing interventions aim to improve proficiency and reach 60% POLST completion by June 2026.

B221 Student Presentation

Optimizing Frailty Assessment in the Outpatient Geriatric Clinic

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Background:

Frailty refers to a state of increased vulnerability in older adults, characterized by physical and cognitive decline that leads to a higher risk of poorer health outcomes, hospital-acquired complications, and increased healthcare costs. Frailty assessment allows clinicians to identify at-risk patients for early interventions. We present the outcomes of a quality improvement (QI) initiative to help improve frailty assessment at the Ambulatory Primary Care Geriatric Clinic at Hackensack University Medical Center.

Methods:

Frailty assessment data were collected for all patients who attended the clinic from 01/01/2024 to 09/30/2025. The QI process was implemented in January 2025. It involved administering the frailty questionnaire to patients, having the provider assess the frailty score, including it in the note template, and capturing the frailty diagnosis in the problem list when positive. The providers were sent weekly reminders about the new workflow. The completion data was reviewed in the monthly division meeting.

Results:

In 2024, the clinic had 2002 patients with at least one visit. The frailty assessment tool was not used as part of the standard workflow. The frailty diagnoses recorded in 2024 were 41 (2.05%). Post-QI in 2025, among 1893 patients, 1127 (59.5%) had a documented frailty assessment, 260 (23.1%) were frailty assessment positive, and 246 (21.8%) received a frailty diagnosis in the problem list. Positive frailty scores were 16.6% at 3, 5.3% at 4, and 1.2% at 5. Among frailty-negative patients, 44.0% were at 0, 15.4% at 1, and 17.5% at 2.

Conclusions:

Our quality improvement model successfully integrated frailty evaluation into the ambulatory workflow and captured patients with frailty. This may provide an opportunity for individualized, proactive, preventative care to help improve outcomes and lower healthcare costs. Larger multicenter sample sizes may be needed to show the persistent benefit of this model in all settings.

B222 Student Presentation

It takes a village: A delirium education intervention to raise awareness and empower patients, families, and caregivers to detect and prevent delirium in the hospital

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Background

Delirium is underdiagnosed in hospitalized older adults due to challenges in staff training and task overload. Family members and caregivers are well positioned to enhance delirium prevention and detection. We developed a delirium educational program for family members and caregivers of hospitalized older adults on an ACE Unit and assessed effectiveness on knowledge and attitudes related to delirium.

Methods

Trained medical students and volunteers recruited patients, family members, and caregivers on the ACE Unit from June-Aug 2025 as part of a multi-modal delirium prevention volunteer program at Memorial Hermann Hospital-Texas Medical Center. Students/volunteers delivered individual delirium education, including risk factors, signs/symptoms, and prevention strategies. Participants completed an anonymous electronic pre- and post-intervention survey evaluating attitudes and self-rated competency at delirium detection, prevention, and management. We analyzed data using descriptive analyses and independent *t*-tests.

Results

Ninety-four people completed the pre-survey and 69 completed the post-survey (42% family/caregiver, 23% patient, 35% other). 61% had never heard of delirium, 33% witnessed it before, and 6% experienced it before. 47% were worried about delirium pre-intervention, unchanged post-intervention. After the intervention, participants reported improvement in: ability to identify delirium symptoms, ability to prevent delirium in their loved one, and perceived self-importance in delirium management ($p < 0.001$ for all). Ability to determine a change in loved ones' behavior and ability to talk to the healthcare team about delirium were rated highly before and after the intervention.

Conclusions

The educational intervention enhanced patient, family member, and caregivers knowledge and confidence in recognizing, preventing, and managing delirium in their hospitalized loved ones. Engaging this group in delirium care represents an important opportunity for healthcare teams to strengthen delirium detection and prevention in the hospital. Future directions include augmenting education with print materials and evaluating impact of the intervention on delirium incidence.

B223 Student Presentation

Hypoglycemic Event Rates of Patients 65+ on Sulfonylureas

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The 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults identified sulfonylurea medications as likely to increase risk of hypoglycemia and subsequently elevate risk of serious related adverse events. We measured clinician adherence from 2012-2025 to the Beers Criteria's strong recommendation against prescribing sulfonylurea medications to adults 65+ years old and the associated outcomes. Prior studies have described prescription trends of individual sulfonylureas, but none included analysis of prescriptions for all sulfonylureas at this scale. Our study used the TriNetX database, a federated health research network that aggregates electronic health record data across 72 health care organizations within the US. Included patients were prescribed a sulfonylurea without an alternative diabetes management medication, did not have a diagnosis of severe renal impairment or a prescription for oral steroids. Alternative diabetes management medications included metformin, GLP-1 receptor agonists, SGLT2 inhibitors, DPP-4 inhibitors, or insulin. Hypoglycemic outcomes were compared to outcomes of patients prescribed alternative diabetes medications, no severe renal decline or oral steroid prescription, and no sulfonylurea prescription. After matching for age at time of prescription, sex, and HbA1C values, 33326 patients prescribed sulfonylureas and 33326 patients prescribed alternative management medications were selected for study. 5665 patients were prescribed glipizide, 3597 were prescribed glimepiride, 914 were prescribed glyburide, and the number prescribed tolazamide or tolbutamide was too small to calculate. Patients prescribed sulfonylureas were less likely to suffer a

hypoglycemic event with a risk ratio of 0.535 (95% CI [0.431, 0.663]) and reported fewer total hypoglycemic events ($t(66257) = -5.59$, $p < 0.001$). Patients prescribed sulfonylureas were also less likely to experience a fall with a risk ratio of 0.646 (95% CI [0.586, 0.713]) and experienced fewer falls than patients taking alternative medications ($t(64399) = -6.85$, $p < 0.001$). Results suggest physician awareness of the hypoglycemic risk and proactive, appropriate physician action to mitigate such risks. There may be potential for physicians prescribing alternative diabetes medications to prevent hypoglycemic events more rigorously.

B224

Focused Eyes on Eating in Dementia (FEED): A Needs Assessment

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Background: About 20% of hospitalized older adults are malnourished, with consequences including increased mortality, readmission, and length of stay. This interdisciplinary project aims to understand and improve management of malnutrition in older adults with dementia and multiple comorbidities at an academic medical center. The first step was to conduct a needs assessment.

Methods: A voluntary and anonymous RedCap survey was emailed to residents and hospitalists to gather data on baseline knowledge, attitudes and practices regarding assessment and management of malnutrition in older adults, including questions about appetite stimulants and feeding tubes. Likert scale, multiple choice, and free text questions were utilized.

Results: 38 respondents completed the survey (22 hospitalist physicians/APPs, and 16 medicine/med-peds residents). 81% of respondents had no prior training in assessing nutritional status, and 86% had no prior training in managing decreased oral intake or weight loss in older adults with multiple comorbidities. 91% of respondents felt appetite stimulants are sometimes or rarely effective in improving intake, and 70% felt they were not at all or slightly familiar with the efficacy, safety and harms of appetite stimulants. In free text responses, most respondents named mirtazapine as the appetite stimulant that they had most often prescribed; commonly cited barriers with assessing nutrition status included poor documentation of weights/intake; barriers experienced with implementing management plans included lack of time, resources, and caregiving support; and non-pharmacological interventions commonly trialed were nutrition consult and protein/calorie supplements. 94% of respondents did not believe that feeding tubes improve survival for older adults with advanced dementia.

Conclusions: The needs assessment highlighted gaps in medical training on the topic of malnutrition assessment and management in older adults, and gave insight on strategies used and barriers faced by frontline providers when addressing malnutrition. We have developed an educational presentation and plan to assess whether it improves providers' confidence about this topic. Our sample had better knowledge of data on feeding tubes in dementia than other studies. Future steps include collaboration with the clinical nutrition team, evaluating appetite stimulant prescribing practices using pharmacy data, and designing a bedside pilot project to improve oral intake in older inpatients with dementia.

B225

Enhancing Geriatric Oral Health Screening in Primary Care: Something to Smile About

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Background: Oral health is essential to older adults' well-being, yet existing screening tools are often time-consuming and require dental expertise, limiting their use in primary care. We led a quality improvement project to increase oral health exams with documentation in an urban geriatrics primary care practice.

Methods: We surveyed providers in a geriatrics primary care clinic to identify barriers to performing and documenting oral exams. In PDSA cycle 1, geriatrics fellows implemented a two-question screen and comprehensive exam adapted from a virtual teaching tool. In cycle 2, fellows collaborated with geriatrics dental faculty to develop a customized 30-second exam with standardized documentation addressing lips, buccal mucosa, tongue, gums, teeth, and dentures as well as defined criteria for urgent dental referral.

Results: Sixteen primary care providers completed the survey; 75% performed oral exams about 25% of the time and 57% documented them half the time or less. Barriers included limited time (31.3%), perceived low importance (12.5%), and limited technique knowledge (12.5%). Between September 30, 2025 and November 18, 2025, 60 patients were seen by the geriatrics fellows (mean age 78.9 years; 71.6% female). Pre-intervention documentation was 64.2%, typically noting only "moist mucous membranes," "normal dentition," or "oropharynx clear." After cycle 1, documentation remained similar (64.7%). After cycle 2, documentation increased to 77.3%, with 88.2% using the standardized template. Following implementation, two patients were referred for urgent dental evaluation for painful, broken dentures and an oral lesion concerning for malignancy.

Conclusion: A brief, standardized oral health exam developed through interprofessional collaboration improved the quality and rate of oral health documentation in a geriatrics clinic and increased detection of abnormalities requiring urgent referral. Future PDSA cycles should engage all practice clinicians in exam training and streamline referral pathways for urgent findings.

B226

Integrating Geriatrics Co-management Into Neurosurgical Care Pathways: Outcomes From a Propensity-Matched Cohort Study

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Background: Older adults undergoing neurosurgical procedures face high risks of adverse outcomes. Evidence for geriatrics co-management in an older neurosurgical population is limited. We evaluated outcomes associated with a geriatrics-neurosurgery co-management program (GNP).

Methods: Retrospective cohort study of adults aged ≥ 65 undergoing spine and brain surgery at a tertiary care level 1 trauma center from July 2022–July 2024. We excluded spine cases discharged ≤ 2 days and brain cases directly admitted to the operating room. Propensity-score matching (1:1) adjusted for age, gender, race, LACE Index, and year created balanced GNP and usual care (UC) cohorts. Outcomes included delirium, complications, ICU admission, length of stay (LOS), in-hospital death or hospice discharge, electrolyte abnormalities, 30-day mortality, and readmission. ICD codes or new

antipsychotic use served as a proxy for delirium. Analyses included bivariate tests and multivariable regression.

Results: We matched 578 patients per group. Mean (SD) age was 78.8 (8.6) years, 46.3% were male, 89.8% were White, and the cohort had a Mean (SD) body mass index of 28.3 (6.5). Most patients were admitted from home (58.4%), followed by skilled nursing facilities (39.4%). GNP had higher LACE scores. GNP patients had lower odds of in-hospital death or hospice discharge (OR 0.38, 95% CI 0.22–0.65), hypernatremia (OR 0.36, 95% CI 0.14–0.89), ICU admission (OR 0.42, 95% CI 0.25–0.71), and 30-day mortality (OR 0.29, 95% CI 0.12–0.71). LOS was longer in GNP (7.9 ± 7.6 vs 4.9 ± 4.6 days). Delirium and readmission rates were similar between groups.

Conclusions: Older neurosurgical patients receiving geriatrics co-management had lower ICU utilization, fewer electrolyte derangements, reduced in-hospital death or hospice discharge, and better 30-day survival, despite longer LOS. Our findings support the need for a formal prospective study to better establish the overall benefit of structured geriatric medicine co-management integration into neurosurgical care for this vulnerable population.

B227 Student Presentation

Don't Let It Fall Through the Cracks: Introducing a Fall Prevention Education Flyer in Primary Care

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Background

Falls are the leading cause of preventable injury and death among older adults. Competing visit priorities and staff burden hinder fall prevention efforts in primary care. This quality improvement project aimed to assess the feasibility and outcomes of incorporating a fall-prevention education flyer into the workflow at a geriatrics primary care clinic (Geri-PCC).

Methods

We followed a root cause analysis approach to create a one-page fall prevention flyer, which was distributed to all patients seen at the HUMC Geri-PCC during December 2024–May 2025. We assessed intervention feasibility with staff surveys and thematic analyses from recorded focus groups. We then compared the rate of hospital admissions and ED visits for falls and hip fractures, and number of referrals to physiotherapy and falls clinic between the pre-intervention (pre), intervention (int), and post-intervention (post) periods using Poisson exact tests.

Results

All of the office staff reported that training for and incorporating the flyer into their workflow took less than thirty minutes over the study period. The majority (5/6) of staff stated the initiative had no impact on their overall workload, while the other (1/6) noted a slight increase in workload. Patient engagement was mixed: many patients declined the flyer, while others overlooked it among other patient surveys. However, several providers stated the flyer encouraged patients to initiate discussions about fall prevention.

Clinical characteristics of our study cohort ($n=910$) reflect our geri-PCC population. Median age was 79. 71% were female and 69% identified as white. 41% had a chart diagnosis of abnormal gait while 26% were frail. Hospital admissions for falls showed a significant decrease from pre to int periods (15 (pre) vs 3 (int); $RR=5$, $p=0.008$). Hip fracture admissions followed a similar trend (10 (pre) vs 1 (int); $RR=10$, $p=0.012$). The decrease was sustained in the post period: $n=7$ for fall admission and $n=6$ for hip fracture. Referrals to physiotherapy and falls clinic were significantly higher in the pre period than in the int and post periods.

Conclusion

Our results show that a fall prevention flyer can be feasibly integrated into a primary care clinic workflow and was associated with reduction in hospital admissions for fall and hip fractures.

B228 Student Presentation

Where does Nursing Home Documentation go?

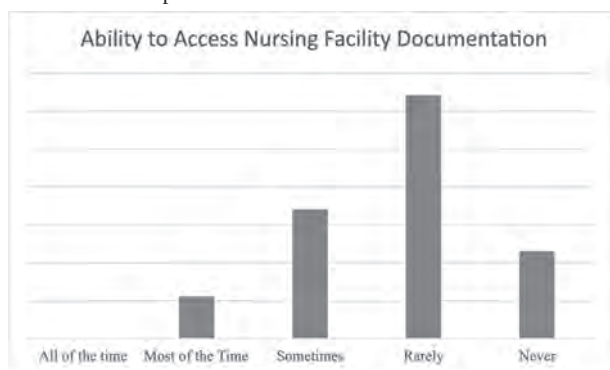
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Background: Access to nursing facility (NF) records at hospital admission impacts safety and quality of care. Federal guidelines require NF to provide records to any receiving medical facility. Though sent by the NF, records from NF are not reliably available. This study evaluated the access to and utilization of NF records by the hospital medical team.

Methods: A REDCap survey was sent to hospital team members to study the accessibility and usage of documentation from NF.

Results: 133 responded, 51.6% were nurses, 32.3% physicians and 6.5% pharmacists. NF records were sought “all of the time” (46.2%) or “most of the time” (27.3%). Respondents reported they “rarely” (48.5%) or “sometimes” (25.8%) located NF records. The location of NF records in the EMR was inconsistent: “Outside Records” (46.2%), “Care Everywhere” (41.5%) or “Media Tab” (22.3%). Respondents reported that poor access to NF records led to medication errors (66.9%) and adverse outcomes (65.1%).

Conclusions: NF documentation is often inaccessible to the healthcare team. There was no standard location in this center’s EMR for NF records. Hospital team members linked communication gaps to medication errors and adverse outcomes. The need for improved integration of NF records into hospital EMRs and the need for safer transitions of care are underscored. Studying the use of NF records on a wider scale is imperative.



Frequency of ability of respondents to locate nursing facility documentation

B229

Beyond the Indication: Deprescribing for Safer Aging.

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Background:

Proton pump inhibitors (PPIs) and H₂-receptor blockers (H₂RBs) are often continued in older adults without a clear indication, despite links to *C. difficile* infection, pneumonia, fractures, micronutrient deficiency, renal injury, and delirium. Guidance from the AGA, ACG, and AGS Beers Criteria recommends limiting acid suppression to evidence-based indications and defined durations. At our university-affiliated skilled nursing facility (LISVH), baseline review showed that over half of residents receiving PPIs/H₂RBs lacked a guideline-supported indication. We implemented a deprescribing initiative targeting a ≥15% reduction in inappropriate therapy.

Methods:

A resident-level review identified all individuals receiving PPIs or H₂RBs (N=148). Indications were categorized using AGA/ACG

guidance and AGS Beers Criteria and classified as appropriate, inappropriate, or indeterminate. For residents without a guideline-supported indication (n=75), individualized recommendations—taper, discontinue, step-down, convert to PRN, or continue—were communicated to primary providers through interdisciplinary huddles and electronic messaging. Final actions were extracted from provider documentation and categorized as deprescribe/taper/step-down, continue, reassess, or other (expired/discharged). Concordance reflected alignment between guideline status and provider action.

Results:

Of 148 residents, 123 (83%) were receiving PPIs and 28 (19%) H₂RBs. Baseline review identified 75 residents (50.7%) without a guideline-supported indication. Provider-verified actions showed that 56 of these 75 (74.7%) underwent deprescribing, tapering, or step-down; 14 (18.7%) were continued (often with documented high-risk features), 2 (2.7%) were designated for reassessment, and 3 (4.0%) had no actionable plan due to discharge or death. Residents remaining on clearly inappropriate therapy decreased from 75 to 14—an 81.3% relative reduction, exceeding the project goal more than five-fold. Provider–guideline concordance was 65.5%.

Conclusion:

A guideline-based deprescribing workflow substantially reduced inappropriate acid suppression in a SNF population. Systematic indication review, direct provider engagement, and use of provider documentation yielded rapid improvements in medication safety. Embedding indication prompts into order sets and adding pharmacist-led audits may support sustainability.

B230

Addressing Antihypertensive Adherence in Older Adults Through a Pillbox Alarm System

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Background

Hospitalizations for acute hypertension (HTN) in older adults rose from 51.5 to 125.9 per 100,000 between 1999 and 2019. Medication nonadherence is a major contributor. Technological aids such as pill organizers with alarms may improve adherence but can be limited by cost and accessibility. This companion quality improvement project aimed to evaluate patient-reported feasibility, satisfaction, and barriers to using a pillbox alarm system within a broader initiative to improve medication adherence and blood pressure control through a structured reminder system.

Methods

We consecutively enrolled patients aged ≥65 years with HTN and an in-office blood pressure (BP) >140/90 mmHg during routine visits to our safety-net geriatric clinic over a one-year period. Patients received a pillbox and alarm device programmed by clinic staff, with twice-monthly in-person nursing visits for BP monitoring and alarm adjustments. We conducted structured telephone surveys to assess accessibility and satisfaction three months after pillbox distribution. Satisfaction was measured using a 5-point Likert scale. Accessibility was assessed through questions evaluating ease of opening the pillbox, organizing medications, and integrating the devices into daily routines.

Results

Thirty-three patients agreed to receive the pillbox alarm system. Of these, 25 (83%) patients and 5 caregivers (17%) completed surveys. Mean participant age was 79 years; 73% were female. Fifty-three percent identified as Hispanic with 63% speaking English, 30% Spanish, and 6% other languages. Two participants (6.7%) used the pillbox alone, 2 (6.7%) used the alarm alone, and 17 (57%) used both devices. All individuals who used the pillbox and/or alarm reported high satisfaction (100%; Likert 4–5). Reported barriers included difficulty resetting alarms, occasional malfunctioning, and the need for assistance with pill organization.

Conclusions

Our patients and caregivers reported high levels of satisfaction with the pillbox alarm system. Survey responses highlighted practical challenges patients encounter when integrating adaptable reminder technologies. Future work will focus on optimizing device setup support, addressing technical barriers, and evaluating long-term feasibility.

B231

Implementing the IHI Age-Friendly My Health Checklist in an Urban VA Outpatient Geriatric Clinic

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Purpose

According to the US Census Bureau, nearly 50% (8.1 million) of our living veteran population in America is 65 years or older. To support Age-Friendly care in various clinical settings, the Institute for Health Improvement (IHI) developed My Health Checklist (MHC), a guide that encompasses the 4Ms framework: What Matters, Medication, Mentation, and Mobility. The objective of this quality improvement project was to implement the use of MHC in an urban VA outpatient geriatric clinic setting to increase veteran and provider preparedness to discuss what is important to the veteran. We aim for an MHC return rate of 30% by June 2026.

Methods

Veterans and/or their surrogates presenting to the West Los Angeles (WLA) VA outpatient geriatric clinic were offered a MHC by the provider during their appointment. The purpose of the MHC was explained, and the receiving parties were asked to review and return the MHC at their next visit. A written reminder was given on the clinic check-out form. Each week, the provider maintained a record of veterans to whom they distributed the MHC as well as the event rate of return.

Results

At the WLA VA geriatric clinic, a total of 16 veterans/surrogates were offered a MHC over the course of 7 weeks. 15 out of the 16 veterans (94%) agreed to receive and return the MHC at their follow up visit. Of the 15 veterans who received a MHC, 1 veteran had a follow up visit within these 7 weeks, but he reported to have misplaced his MHC and requested another. At this time in the study, the initial return rate of the MHC is 0%, as only 1 veteran has had a follow up appointment. The average time between appointments is 3-6 months, and a root cause analysis will be performed after 3 months to develop countermeasures to address any discrepancies between the actual return rate and the goal rate (30%).

Conclusions

The majority of veterans/surrogates at the WLA VA geriatric clinic were amenable to receiving and reviewing the MHC. The majority also expressed appreciation that the clinic provided this checklist, as many of them were interested in thinking about different aspects of their healthcare and found reassurance in their provider. Future PDSA cycles will evaluate additional countermeasures to refine the MHC distribution workflow and therefore improve the return rate, and potentially expand the MHC workflow to other VA geriatric clinics.

B232 Resident Presentation

Opioid and Benzodiazepine Utilization and Monitoring Practices in Outpatient Geriatric Care Centers

S. Lee, A. Grimes, b. Proddutur. *Medical Education, UPMC St Margaret, Pittsburgh, PA*.

Purpose/Background

The CDC has provided guidance on opioid monitoring, including controlled substance agreements (CSAs), annual Urine Drug Screens (UDS), Prescription Drug Monitoring Program (PDMP) checks, and providing naloxone to promote safer prescribing and monitoring for patients on high-risk chronic opioids.¹ Currently, our two geriatric

clinics have a standard process for PDMP checks and CSAs, though processes are not consistently reviewed and documented across all four metrics. Our study aims are to assess opioid and benzodiazepine (BZD) utilization and monitoring, and educate providers and staff on best practices.

Methods

This is a pre-post intervention quality improvement project conducted across two outpatient geriatric primary care clinics. Prescribers/staff members were educated on the workflow/documentation with a presentation (prescribers only), emailed flyer, posters displayed in office, and personal reminders. Retrospective chart review was performed. Electronic health record was used to identify patients with prescribed opioids and/or BZDs between June 1, 2025, to September 30, 2025 (pre period) and November 17, to March 14, 2026 (post period). Patients included were taking opioids and/or BZDs for >3 months prescribed by clinic prescribers. Patients were excluded if medications were prescribed by palliative care/psychiatry. Data collected was: age, medication, duration of use, compliance/documentation of annual CSAs, ordering/collection of annual UDS, PDMP checks, naloxone counseling/dispensing, and number of visits. The primary outcome is the proportion of patients who comply with all four metrics pre and post intervention. Secondary outcomes include the proportion of patients meeting each criterion. The analysis used descriptive statistics.

Results

Eleven prescribers and seven staff members completed education. There were 134 patients identified as receiving opioid and BZDs in the pre-period. Anticipated results will show the effect of a new workflow on opioid and BZD stewardship in older adults.

Conclusions

These results will be used to optimize outpatient opioid and BZD use and monitoring in this outpatient geriatric primary care center and may be expanded to other controlled substances.

References:

1. Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4. doi:10.15585/mmwr.r7103a1

B233 Resident Presentation, Encore Presentation

Enhancing Palliative Care Referrals for High-Risk, Aging Veterans Using Predictive Analytics: A QI Project at the Boise VA

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Background: Advance Care Planning (ACP) remains underutilized in primary care despite its role in identifying goals of care for older adults. Within the Veterans Health Administration (VHA), ACP discussions are mandated for patients with Care Assessment Need (CAN) scores ≥ 95 . At the Boise VA Silver Team Clinic, 13% of high-risk older veterans (CAN ≥ 98) had received an outpatient palliative care referral over five years, indicating a missed opportunity to align care with patient preferences and meet national directives. Our objective was to increase outpatient palliative care referral rates from 13% to 25% using predictive analytic CAN scores ≥ 98 in the Boise VA Silver Team Clinic by May 2025 through workflow redesign and team education.

Methods: This QI project took place in a primary care clinic serving ~5,000 older veterans. Participants included attending physicians, internal medicine and nurse practitioner residents, nurses, a palliative care coordinator, and clinic leadership. Using Lean principles and four Plan-Do-Study-Act cycles from September 2024 to February 2025, the team integrated nurse education to flag patients with CAN ≥ 98 for

providers to place palliative care consults, incorporated CAN-based prompts into interdisciplinary case reviews, retrained staff after EHR updates with CPRS banner reminders, and educated residents on CAN score interpretation with pre/post surveys. The primary outcome was the proportion of veterans with CAN ≥ 98 receiving an outpatient palliative care consult. Secondary outcomes included consult volume and LST/AD documentation, and resident confidence in palliative care.

Results: Referral rates increased from 13.3% to 24.8%, with monthly consults more than doubling. LST/AD documentation increased from ~200 to >350 patients. 17 residents completed surveys, demonstrating improved confidence in locating and applying CAN scores. Common barriers included limited time, patient reluctance, and coordination challenges.

Conclusions: Integrating predictive analytic CAN score review into primary care workflows nearly doubled outpatient palliative care referral rates for high-risk older veterans. Low-resource interventions, team engagement, and consistent reinforcement improved ACP implementation.

B234

Nudging the Next Step: A Design-Driven Intervention to Improve Walking Speed Care

T. Johnson,² S. Tietz,² C. Dahal,¹ A. Keniston,² H. Lum,² J. Pell.²
1. UCHHealth, Aurora, CO; 2. Medicine, University of Colorado School of Medicine, Aurora, CO.

Background:

Walking speed is a concomitant and modifiable biomarker for physical functioning and overall health in older adults. At an academic primary care geriatrics clinic, 25% of patients were found to have critically low walking speeds. Only 43% of those patients were referred to physical therapy (PT) in the last 6 months. A quality improvement initiative investigated how to improve this referral rate to above 50%.

Methods:

A design workshop was conducted with the medical assistant (MA) team. A nudge intervention was developed utilizing the design thinking cycle where MAs would pend PT referral orders in the electronic health record if a patient had a low walking speed and not seen PT in 6 months. The provider would then be prompted by the pended order to address whether the patient needed a PT referral and could easily sign the order. A physical therapist staffed gym was also installed in the clinic. Therapists in the gym performed both scheduled and walk-in visits for evaluation and treatment including these “warm handoff” referrals.

Results:

From January 1, 2023 through March 31, 2025, 3142 gait speed measurements were obtained. The integrated physical therapy team was initiated in April of 2024, the nudge intervention began July 2024. Physical therapy referral rate in patients with low walking speed showed a statistically significant improvement from 43% preintervention to 54% postintervention.

Conclusions:

A design workshop with an MA team was able to create a successful nudge to improve physical therapy referrals for patients with critically low walking speeds. Embedding a PT in clinic improved availability for this new increase in referrals. The design thinking cycle steps of empathize, define, ideate, prototype, and test offer an interesting corollary to the Model for Improvement. When combined, this has been called “human-centered quality improvement” which seeks to empathize and understand the human perspective to improve systems¹. This quality improvement project demonstrates a real-world successful application of combined design thinking and quality improvement principles.

Citations:

1. Crowe B et al. To improve quality, leverage design. *BMJ Qual Saf.* 2022 Jan;31(1):70-74. doi: 10.1136/bmjqs-2021-013605. Epub 2021 Sep 11. PMID: 34510018; PMCID: PMC8685615.

B235

What Matters Most to Older Veterans: A Quality Improvement Intervention in a Community Living Center

T. K. Hagerman, M. Gettle, E. Akabike, L. Lamb, R. Afshan, J. Kelly, J. Beal, A. Norcott. *Division of Geriatric and Palliative Medicine, University of Michigan, Ann Arbor, MI.*

BACKGROUND

Identifying and tailoring care plans to what matters most (WMM) to older adults is a cornerstone of quality geriatrics care. Our aim was to evaluate current care processes and perspectives from interdisciplinary team (IDT) members to inform a future quality improvement (QI) intervention.

METHODS

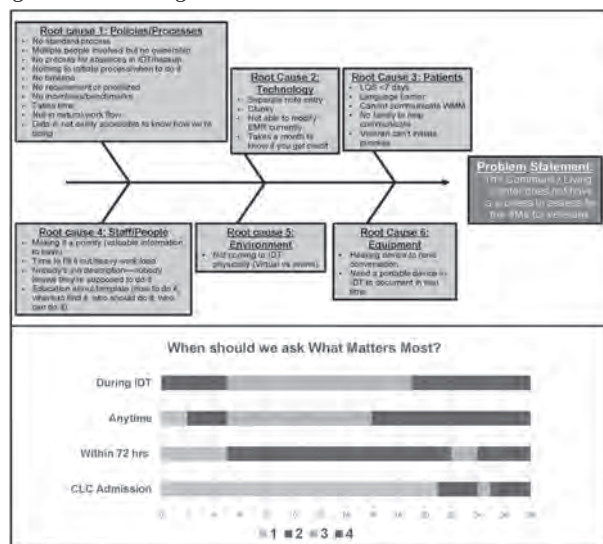
We conducted a QI project in a single Veterans Affairs rehabilitation center. We first interviewed IDT members to understand the current workflow. We then distributed an anonymous online survey to IDT members to describe current practices for eliciting and documenting WMM.

RESULTS

We conducted stakeholder meetings with 5 IDT members (Fishbone diagram). A total of 28 IDT members completed surveys, including 8 physicians, 3 advanced practice providers, 2 nurses, 5 physical or occupational therapists, and 10 other disciplines/ not reported. IDT members reported being familiar with the 4Ms (86%) and that they had an existing workflow to elicit and document WMM to Veterans (71%).

CONCLUSION

Our current process for eliciting and documenting WMM to Veterans in the rehabilitation center lacks standardization. Future work should explore the impact of a standardized approach to capturing and documenting WMM to Veterans.



Top: Fishbone Diagram. Factors contributing to limited documentation of What Matters Most to Veterans in the Community Living Center. Data came from key stakeholder surveys. Bottom: Interdisciplinary Team Member survey responses. Members were asked to rank the choices from 1 to 4 with 1 being the best time to ask and 4 being the least ideal. Abbreviation: IDT, interdisciplinary team; EMR, electronic medical record; LOS, length of stay; WMM, What Matters Most.

B236 Student Presentation

Workflow Optimization for Asking What “Matters Most” in Geriatric Primary Care

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Background:

Multimorbidity among older adults can complicate clinical decision-making, particularly when patients’ priorities and goals are unknown or conflicting. Incorporating patient goals—what “matters most” (WMM)—can reduce treatment burden, unwanted interventions, and unnecessary utilization, while improving communication. Evidence shows older adults can articulate WMM via structured tools, including one developed by Moye et al. Little is known about integrating tools into clinic workflows and electronic health records (EHRs). This project assessed the use of a standardized WMM tool into routine geriatric primary care visits, aiming to: (1) evaluate workflow integration; (2) assess provider perspectives; (3) identify key components for EHR integration.

Methods:

This cross-sectional quality improvement study was conducted over three weeks. Patients scheduled with two providers were offered the WMM form at check-in, and could complete it during rooming. Forms were reviewed by the provider and scanned into the EHR. Measures included forms distributed, form completion, and commonly selected components. Team perspectives were assessed through brief focused interviews. Data were analyzed descriptively.

Results:

During the pilot, 81 forms were distributed across 133 visits, with 76 at least partially completed. Of form components, 95% of patients identified initial values, 47% selected top 3 values, and 70% identified healthcare goals. The most commonly selected values centered around mentation, mobility, enrichment, and connection. Greater than half of patients identified “have good relationships with family or friends” (70%), “spend time with family and friends” (66%), “think clearly” (64%), and “walk or move around by myself” (58%). Provider interviews indicated that the WMM form supported patient reflection and helped them understand priorities, especially for new patients. Suggested improvements included simplifying the form due to time constraints.

Conclusions:

Initial findings suggest that integrating a structured WMM form into routine care is feasible and acceptable. This work identified insights to guide EHR integration of this tool. Future efforts will refine the tool, guide EHR development, and assess patient-reported outcomes in broader implementation.

B237

An Immersive Dementia Experience as a Catalyst for Reducing Antipsychotic Use

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Background: In 2023, 20.4% of individuals living in nursing homes (NH) in the US received antipsychotic medications (APM). Most APM were prescribed for off-label indications and most often for individuals with dementia. There is evidence that antipsychotics can cause harm in older adults and judicious use of APMs is needed. Non-pharmacological interventions are recommended first-line for behaviors, but APM are often perceived as an easier or more efficacious solution.

Methods: This QI project aims to reduce APM use at a NH in Maryland. The percentage of APM use was derived using the number of routine prescriptions divided by the daily census at the end of each month. PDSA cycles included a pharmacist-led session on APM and

side effects, a physician-led session on non-pharmacological interventions, and an immersive dementia training followed by best practices sharing. A statistical process control (SPC) chart was used to analyze APM use over time. Pre-and post- surveys were administered during the third PDSA cycle to assess staff confidence and knowledge.

Results: 41 staff participated in the immersive training including RNs, LPNs, and GNAs. Participants reflected on feeling confused and easily frustrated by the challenges simulated in the training. They found the training to be effective in helping them understand the sensory and cognitive challenges experienced by people living with dementia. At baseline, 87% of participants expressed confidence in managing behaviors associated with dementia without relying on APM. The most common strategies used were redirection or engaging residents in conversation. SPC analysis demonstrated a decline in APM use from 19.4% in Sept 2024 to 11.5% in Mar 2025 but did not yet show special cause variation.

Conclusion: Multidisciplinary initiatives are effective in reducing APM use but there is need for iterative processes for sustained reductions. Further data is needed to assess the long-term impact of these PDSAs. Future directions include prescriber training and multidisciplinary chart reviews to facilitate gradual dose reductions, as indicated.

B238 Student Presentation

Improving Prescribing Safety in Hospitalized Older Adults:

How to Communicate Effectively and Efficiently over SMS Alerts for Potentially Inappropriate Medications

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Background:

The complexity of multiple morbidity among older adults ages 80+ years creates challenges in addressing polypharmacy, the use of ≥5 medications, and potentially inappropriate medication (PIM) use. This study analyzed the quality improvement (QI) project’s effects of a Secure Messaging System (SMS) intervention on documentation of polypharmacy and deprescription of PIMs in older adults by healthcare providers (HCPs).

Methods:

Between July and October 2025, as part of an ongoing QI project, any patient aged 80+ admitted to the hospitalist service, taking at least one PIM, and meeting the polypharmacy criteria was identified by chart review. Those who met the listed criteria had SMS alerts sent to their HCPs. During this time, 3 phases of SMS templates were developed utilizing rapid Plan-Do-Study-Act cycles and incorporating stakeholder feedback. At the end of phase 3, 19 variations were developed and disseminated. Patient intake/discharge information, including PIMs, total medication count, and presence of polypharmacy documentation in the medical record, was documented.

Results:

Patients (N=56) received the SMS intervention with a mean age of 86 (range: 80-104). Patients took a mean of 15.3 (range: 6-35) total medications and 1.7 PIMs at intake. At intake, 8.9% of medical records included polypharmacy documentation. At discharge, 19.6% included polypharmacy documentation. Patients took a mean of 13.1 (range: 0-29) medications total at discharge. A mean of 0.7 PIMs was deprescribed.

Conclusions:

A SMS is a feasible approach to alert providers about polypharmacy and PIMs in hospitalized adults aged 80+. Following intervention, both total medication and PIM use decreased. Polypharmacy documentation remained low, indicating HCP awareness alone may not prompt action.

Acknowledgements:

Institute for Health Improvement Seed Grant, The Harry Albertman Endowment

B239

Earlier Detection of Medication Errors Through an Optimized Post-Discharge Transitional Care Management (TCM) Workflow

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Background: Significant medication errors on discharge from the hospital are common and can lead to serious adverse outcomes for older adults. The inpatient Geriatrics service at Mount Sinai Hospital has a transitional care management (TCM) workflow protocol which addresses a patient's medication changes during admission, endorses the information to the primary care physician and confirms it with patients on a phone call within 48 business hours of discharge, and during an in-person visit within 2 weeks. While the process successfully detects medication errors, a data review showed that medication errors were not accurately detected during phone calls, but rather during post discharge visits at 1-2 week follow up. This significant delay in detection of medication error introduces concern for patient safety. This QI project focuses on improving the way medication changes are communicated during the hospital discharge process.

Methods: Discharges from the inpatient geriatrics services from April through June, 2025 were reviewed, and the number of medication errors detected on TCM call and visits were collected. Medication error detected on TCM call in the 2-months period was 33% (3 out of 9), while 66 % (6 out of 9) were identified at post discharge visit. Geriatric Fellows who make TCM calls were surveyed to identify barriers for earlier detection of medication errors. A focused educational intervention on detection of medication error and how to standardize documentation of a medication reconciliation phone call was implemented.

Results: In order to achieve earlier medication error detection (on TCM call rather than visits), a PDSA cycle one was created to standardize the documentation of medication changes and questions asked during medication reconciliation on the TCM phone call. The aim is to increase the proportion of medication discrepancies detected and addressed during the TCM post-discharge call process from 33% to 38% by April 30, 2026.

Conclusions: Although the TCM process is helping in detecting medication error there are still improvements to be made. A standardized process to improve education of fellows surrounding post discharge medication reconciliation and documentation can help improve earlier detection of medication discrepancies and promote patient safety.

POSTER SESSION C (STUDENTS & RESIDENTS)

Friday, May 1

2:45 pm – 3:45 pm

C1 Resident Presentation

Goals-Centered Medication Simplification in a PEG-Dependent Older Adult

A. Kamr Aldin,² Z. Salomon,² S. Zhitomirsky.¹ *1. Internal medicine, Ryan Health, New York, NY; 2. Internal medicine, Mount Sinai Morningside/West, New York, NY.*

Introduction: Polypharmacy is common in older adults with multimorbidity. In patients who rely on PEG tubes for medication administration, risks such as drug incompatibility with nutrition or inappropriate dosage form selection are increased. Frequent transitions of care, fragmented prescribing practices, and limited oral intake further complicate management. This case presents a creative, goals-centered strategy to regimen adjustments in an older adult with severe dementia and PEG-dependence.

Case Presentation: Mr. A is a 90-year-old man with severe dementia, prior subdural hematoma, insulin-dependent diabetes, and

PEG-tube dependence after multiple hospitalizations in 2024. He remained minimally mobile, responsive to simple commands, and lived at home with 24-hour caregiving. In April 2025, his regimen included over 15 medications, many used on an as-needed basis without clear routines or given through the PEG despite inappropriate formulations. The family reported repeated tube clogging, difficulty crushing pills, inconsistent administration of medications, and unpredictable glucose and bowel patterns. They strongly prioritized care at home and wished to maintain care they perceived as beneficial while avoiding burdensome interventions.

A structured medication review led to deprescribing of low-benefit agents such as statins, simplification of the pain and bowel regimens, and identification of medications requiring compounding. By September 2025, nearly all medications had been converted to liquid or powder form. The family reported fewer PEG-clogging events, better control of pain and constipation, and improved alertness and oral intake.

Discussion: This case highlights the importance of a collaborative, patient-centered approach to medication management, driven by both clinical appropriateness and the family's cultural expectations, goals, and preference for stability. A major limitation is that the approach taken was not guided by existing studies or established evidence and was limited by the availability of formulations and administration methods suitable for PEG use. The patient's improvement illustrates how excessive pill burden and inappropriate formulations can significantly impair functional status in advanced dementia, while also demonstrating the importance and the challenge of employing creative, individualized approaches in a landscape with limited practice guidelines.

C2 Resident Presentation

Too Old for Treatment? TAVR-First Strategy in an Octogenarian with Left Main Disease

A. Rizzo, R. Prentice. *Department of Medicine, Brooke Army Medical Center, San Antonio, TX.*

Severe aortic stenosis (AS) and coronary artery disease (CAD) commonly coexist in older adults. Trials of percutaneous coronary intervention (PCI) before transcatheter aortic valve replacement (TAVR) have excluded patients with left main (LM) disease and frailty, leaving limited guidance. We report an octogenarian in whom a TAVR-first strategy was chosen using a geriatric decision framework.

Single patient case study from a tertiary center. A multidisciplinary heart team (MDT) used geriatric principles and shared decision-making to decide between a TAVR-first versus pre-TAVR PCI strategy.

An 84-year-old man with autoimmune hemolytic anemia requiring IVIG and blood transfusions, vertigo with gait unsteadiness and falls, peripheral arterial disease, atrial fibrillation on dabigatran, CAD with prior 1 vessel CABG, and severe AS presented with progressive angina and dyspnea occurring after walking 10 feet. Angiography identified obstructive CAD involving the distal LM and an atretic, nonfunctioning LIMA graft. The patient was cognitively intact and desired a return to functional independence and improvement of quality of life but believed he was "too old" for invasive treatment. His Essential Frailty Toolset score was 3 (28% 1-year predicted mortality with TAVR)¹. From a Cardiology perspective, the patient's LM CAD and symptom burden typically favor PCI prior to TAVR but this would require the addition of antiplatelet therapy to ongoing anticoagulation². In an anemic older adult with recurrent falls, the bleed/mortality risk would further increase. Applying a geriatric framework (frailty, falls, bleed risk, time-to-benefit versus time-to-harm) along with incorporation of patient's goals, the MDT selected a TAVR-first strategy which was performed without complication. On post-operative day 1, he was able to walk multiple laps on the ward without exertional dyspnea or angina. At 2-year follow up, he remained symptom free and independent in daily activities, ambulating in the community without limitation (Berg Balance Scale 41/56). He continues to decline LM PCI despite understanding guideline supported indications.

This case highlights the need to use geriatric principles to align heart team decisions in elderly patients with severe AS and LM CAD³.

1. doi:10.1016/j.jacc.2017.06.024

2. doi:10.1161/CIR.0000000000000923

3. doi:10.1161/CIR.0000000000001387

C3 Resident Presentation

Third-Degree Atrioventricular Block Presenting as Recurrent Syncope in a Geriatric Patient on Donepezil

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Background: Third-degree atrioventricular (AV) block is an uncommon but serious cause of syncope in older adults. While age-related conduction disease is the most common etiology, medications such as acetylcholinesterase inhibitors can exacerbate AV nodal dysfunction. Donepezil, widely prescribed for dementia, enhances vagal tone and has been associated with bradyarrhythmias.

Case: A 67-year-old female with dementia presented after a witnessed syncopal episode at home, lasting ~1.5 minutes with eye deviation and tongue protrusion but without trauma. On admission, she was hemodynamically stable. Workup revealed hemoglobin 11.8 gm/dL and urinalysis consistent with acute cystitis. She was treated with intravenous ceftriaxone and fluids. Her home donepezil was initially held but restarted on hospital day two. On day three, she developed a recurrent syncopal event while seated in bed, which she spontaneously recovered from within 10 seconds. Telemetry captured a prolonged absence of ventricular activity (~20 seconds) with subsequent complete AV dissociation, consistent with third-degree AV block. Electrocardiogram showed sinus rhythm with first-degree AV block (PR ~220 ms) and left anterior fascicular block. The episode occurred four hours after donepezil dosing. Prior to this episode, telemetry showed normal sinus rhythm. She was transferred to the cardiac care unit, where she underwent dual-chamber pacemaker implantation. Donepezil was continued on discharge.

Discussion: This case illustrates the intersection of age-related conduction system disease, polypharmacy, and geriatric vulnerability. While idiopathic fibrosis likely contributed, donepezil may have exacerbated AV nodal dysfunction. By increasing acetylcholine levels and vagal tone, donepezil can prolong the PR interval and impair conduction, progressing to complete heart block. In this patient, the temporal association between donepezil use and recurrent third-degree AV block highlights the need to consider medication effects in hospitalized patients.

Conclusion: Although rare, donepezil should be considered as a potential contributor to bradyarrhythmia in patients with dementia. Effective management of conduction disease in geriatric patients requires multidisciplinary care and careful evaluation for causes of syncope including complete heart block.

C4 Resident Presentation

From Independent to Bedbound in Months: Looking Past Dementia in Failure to Thrive

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Background: Significant cognitive and functional decline in older adults is often attributed to a diagnosis of dementia, and additional workup is often thought to not change management. We present a case highlighting the importance of broadening the differential diagnosis when evaluating failure to thrive; our patient had a rare complication of ulcerative colitis (UC).

Case: A 71-year-old woman with UC on sulfasalazine, asthma, and hyperlipidemia was admitted from home, where she lived with her brother. 1 year earlier, she had been independent of ADLs and working remotely at an insurance company, though she had few years of gradually worsening forgetfulness, visuospatial issues, and driving mishaps. Over the last 3 months, she lost 16 pounds, had worsening urinary and fecal incontinence, was increasingly refusing food and medications,

and requiring increasing ADL and mobility assistance. She had low-grade fever and anemia on arrival. Early evaluation focused on medication adjustments for depression and pain, and starting goals of care discussions. She was treated for *C. difficile* infection but continued to have mild lower abdominal tenderness. Geriatrics recommended abdominal imaging due to her anemia, UC and strong family history of colon cancer. CT abdomen/pelvis showed a large multiloculated pelvic abscess with contained rectosigmoid perforation, diffuse colitis, ascites, and extensive left iliac/femoral DVT. She was started on anti-coagulation, broad-spectrum IV antibiotics, and underwent IR drainage of the abscess, with GI, ID, and surgery input. Despite this, she continued to decline. Her brother (healthcare proxy) ultimately felt that major abdominal surgery, colostomy, or tube feeding would not align with her wishes. She passed away 2 months after the initial presentation.

Conclusion: It is important to avoid premature closure on a diagnosis of "just dementia" in older adults with rapid decline. Comprehensive geriatric assessment can help guide work-up to explore occult diagnoses in patients who cannot reliably express themselves. Our patient had colonic perforation without dilatation, which is a rare complication of UC and may present without signs of peritonitis, per the literature. Multidisciplinary input and early discussions about patient goals and preferences should guide the treatment plan.

C5 Resident Presentation

Pott's Disease in a Nonagenarian with Advanced Dementia

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Background: Pott's disease, or spinal tuberculosis (TB), can manifest with back pain, neurologic deficits or spinal instability. In the USA, TB has higher incidence and prevalence in older compared to younger age groups, especially among migrants and those with diabetes, immunocompromise and social vulnerabilities. The clinical context of dementia in this population can further complicate management of Pott's disease.

Case: A 93-year-old female from Central America with a history including dementia, DVT, PTSD, and vertebral osteomyelitis with epidural abscess/phlegmon at T12/L1 refractory to 6-week IV vancomycin and ceftriaxone course (after negative initial biopsy) presented to the ER from outpatient MRI with concerns for persistent back pain and vertebral osteomyelitis/phlegmon after 5 months. Paired with a positive QuantiFERON gold test for latent TB 6 months prior, she was treated for Pott's disease, and PCR testing of new biopsy confirmed *M. tuberculosis*. She was offered rifampin and ethambutol with the expectation to continue treatment for 1-2 years, and plan for slower outpatient introduction of 2 agents. However, with her advanced dementia (bedbound, total care, declining oral intake), there was concern for medication intolerance, and the possibility of transitioning to hospice care at the point of nonadherence was explored prior to discharge. The patient's home apixaban was changed to subcutaneous enoxaparin due to interactions with rifampin. The family's preference was to trial long-term therapy after extensive discussions. On short term follow-up, she could not tolerate adding fluoroquinolone due to possible seizures.

Discussion: Treatment for spinal TB usually involves 4-drug regimen for 2 months, then 2 drugs thereafter, and surgery if indicated. In patients with dementia, management of Pott's disease requires investigation into the patient's frailty, functional status, home supports and home medications, ideally through a comprehensive geriatrics assessment, to delineate expectations regarding feasible treatment options for patients living with both diseases. This approach includes considerations ranging from medication compliance, side effects, monitoring requirements, to quality of life.

Conclusion: Pott's disease in older adults with advanced dementia has a high treatment burden and requires a holistic multidisciplinary approach with early goals of care when considering treatment plans.

C6 Resident Presentation

Incidental Discovery of Chronic Lymphocytic Leukemia (CLL) During Hospitalization for Cellulitis

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Background

Chronic lymphocytic leukemia (CLL) is a hematologic malignancy frequently diagnosed in geriatric populations. These patients are at increased risk for infections due to age-related underlying immune dysfunction.

Case

94-year-old male admitted to the hospital with sepsis secondary to lower extremity cellulitis. The cellulitis was complicated by streptococci, beta-hemolytic group G bacteremia. On physical exam, patient had cellulitis of the right lower extremity with bullae formation. Patient was placed on IV ceftriaxone and IV doxycycline. The patient responded to antibiotic therapy and showed clinical improvement, but his absolute lymphocyte count continued to rise. This atypical hematologic trend prompted further investigation. Peripheral blood smear and flow cytometry were completed. Blood smear showed absolute lymphocytosis with smudged cells, suspicious for a lymphoproliferative disorder. Flow cytometry showed diagnosis of monoclonal B-cell population with an immunophenotype suggestive of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), CD38 negative. Patient's cellulitis improved after course of antibiotics and scheduled for outpatient bone marrow biopsy.

Discussion

This case highlights the importance of maintaining a broad differential diagnosis in elderly patients presenting with infection and abnormal laboratory values despite appropriate antibiotic course. Specifically, it values the use of daily complete blood counts with differentials in monitoring not only infection progression but also in helping discover underlying hematologic disorders. This case demonstrates that a patient with unknown CLL may first present with an acute infection such as cellulitis. Early recognition of these patterns can significantly influence the early detection of hematological disorders such as malignancy, as well as long-term management and prognosis. Overall, this case supports the need for vigilance when interpreting lab trends in older adults, especially when clinical findings and physical exam deviate from a typical presentation.

C7 Resident Presentation

Recurrent Opioid Overdose and Multisystem Complications in an Older Adult Patient with Chronic Pain: Challenges of Polypharmacy and Multimorbidity.

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Managing chronic pain in older adults with multiple comorbidities is complex. This case describes a 70-year-old woman with chronic pain, fibromyalgia, advanced CKD, and a history of lung cancer, who experienced recurrent opioid overdoses with serious multisystem complications. From 2021 to 2025, this retired healthcare aide was hospitalized 5 times for unresponsiveness and respiratory failure, each episode linked to unintentional opioid overdose in the context of chronic opioid and benzodiazepine use, advanced CKD, and other comorbidities. Her hospitalizations were complicated by acute kidney injury, aspiration pneumonia, ischemic hepatitis, and cardiac arrhythmias, ultimately resulting in dialysis dependence. Despite medication adjustments and overdose education, she continued to have life-threatening events. During her final admission, formal screening identified mild opioid use disorder. She was transitioned to buprenorphine for pain management and is now followed in a primary care-based clinic.

Discussion:

This case highlights the vulnerability of older adults with multimorbidity to opioid toxicity, particularly with renal impairment and

polypharmacy. Progressive CKD reduced opioid clearance, increasing the risk of accumulation and toxicity. Concurrent use of benzodiazepines and barbiturates further potentiated central nervous system and respiratory depression. The patient experienced recurrent cognitive impairment, falls, and delirium, worsened by sedative burden and acute illness. Despite interventions, pain control remained difficult, necessitating a switch to buprenorphine, which may be safer in advanced CKD. Fragmented prescribing, lack of coordinated medication reconciliation, and limited access to non-opioid pain management contributed to recurrent events. Formal SUD screening was essential in identifying OUD and guiding management.

Conclusion:

Recurrent opioid overdose in older adults with complex medical histories can lead to multisystem organ failure and significant morbidity. Team-based care, regular medication review, and integrated pain and substance use disorder management are critical to improving outcomes in this population.

Clinical Timeline of Hospitalizations and Interventions

DATE	PRESENTATION/FINDINGS	INTERVENTIONS/DISPOSITION
09/2021	- Somnolence, hypotension, respiratory depression after prescribed pain meds. - Labs: Severe AKI (Cr 11.5, baseline <1.0), hyperkalemia, elevated CK.	- IV naloxone, pressors, fluids - Oxycodone and fentanyl/acetaminophen/caffeine discontinued - Hydrocodone/acetaminophen continued - Discharged with naloxone; no follow-up attended.
03/2023	- Found unresponsive in car. Code 99 initiated. - Intubated, received naloxone.	- Pain regimen reduced from 120 to 90 MME.
05/2023	- Hypotension, respiratory failure - Required intubation, naloxone drip. - Labs: AKI (Cr 4.2), hypokalemia, troponin elevation.	- Oxycodone restarted at reduced dose. - Held antihypertensives per nephrology - Discharged with overdose education and naloxone.
10/2025	- Found unresponsive at home, bradycardic, hypotensive. - Encephalopathy, aspiration pneumonia, shock liver, AKI (Cr up to 7.4), NSTEMI arrhythmias.	- Required hemodialysis. - Transitioned to buprenorphine patch, later switched back to low-dose oxycodone.
11/2025	- Presented from dialysis with confusion, somnolence. - On naloxone infusion for suspected opioid toxicity - Imaging: new pericardial/pleural effusions, left lower lobe atelectasis. - Labs: severe hypokalemia, acute anemia. - Formal SUD screening: mild OUD (escalating use, early refills, use of husband's prescription, continued use despite harm).	- IV potassium, antibiotics, transfusion - Buprenorphine patch and sublingual tablets for pain - Outpatient follow-up arranged - Transitioned to Primary care based MOUD clinic for ongoing pain and OUD management.

C8 Resident Presentation

Chronic Morel-Lavallée Lesion After a Ground-Level Fall in an Older Adult

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Background: A Morel-Lavallée lesion (MLL) is a closed degloving injury in which separation of superficial and deep fascia creates a fluid-filled space that may progress to a chronic collection of blood and debris. MLLs usually result from high-energy trauma and are rare after low-energy falls.^{1,2}

Methods: A 69-year-old woman with hypertension, hyperlipidemia, and asthma presented with left hip swelling 4 years after a fall. Initial erythema, pain, and edema partially resolved, but swelling remained with mild discomfort when dressing or lying on the side. X-ray was unremarkable at the time of injury. Exam revealed a large, fluctuant, mildly tender, non-erythematous mass. Ultrasound showed an 8.5×5.2×1.6 cm anechoic collection in deep subcutaneous tissue. MRI demonstrated a 5.1×4.6×0.9 cm fluid collection between subcutaneous fat and the tensor fascia lata with T1/T2 hyperintensity and rim enhancement, consistent with chronic MLL. Symptoms prompted plastic surgery referral for consideration of surgical removal.

Results/Discussion: MLLs most often occur over the greater trochanter after high-energy trauma.^{1,2} They can also occur in older adults after minor injury, especially with anticoagulation.³ Early recognition prevents lesion expansion, necrosis, and infection.^{2,3} Age-related loss of connective tissue elasticity may predispose this population.⁴ Persistent swelling after low-energy trauma should prompt consideration of MLL, with MRI to distinguish it from hematoma, bursitis, or sarcoma.² This case illustrates that minor trauma in older adults can produce clinically significant MLLs.

Conclusion: MLLs should be considered in older adults with chronic soft tissue swelling after low-energy trauma, as early diagnosis reduces complications.

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C9 Resident Presentation

Case Report: Atypical Presentation of Anaplasmosis in a 74 Year Old Male in Maine

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Background:

Anaplasmosis, caused by *Anaplasma phagocytophilum* and transmitted by the black-legged tick (*Ixodes scapularis*), is increasingly prevalent in the northeastern United States, particularly among older adults. Older adults are at higher risk of severe disease, atypical presentations, and diagnostic delays.

Case:

74-year-old man from Maine who presented with acute confusion, weakness, fever, myalgias, and malaise following recent tick exposure. Laboratory evaluation revealed leukopenia, thrombocytopenia, mildly elevated transaminases, and acute kidney injury, highlighting the potential for organ dysfunction in geriatric patients. No rash was observed initially, complicating early recognition. Empiric doxycycline therapy was initiated based on clinical suspicion. On hospital day five, the patient developed a peripheral petechial rash, prompting evaluation for Rocky Mountain spotted fever (RMSF); PCR testing confirmed *Anaplasma phagocytophilum* and excluded RMSF. The patient improved rapidly with treatment.

Discussion:

This case underscores that older adults may present with atypical and severe manifestations of human granulocytic anaplasmosis (HGA), including encephalopathy and organ dysfunction, which require prompt recognition and treatment. Preventive strategies, including caregiver-assisted tick checks, protective clothing, repellents, and environmental modifications, are essential to reduce morbidity in this vulnerable population. Clinicians should maintain a high index of suspicion for tick-borne illnesses in older adults living in endemic regions.

C10 Resident Presentation

Integrating the Age-Friendly 4Ms Framework with Frailty Assessment to Improve Colorectal Cancer Surgery Outcomes

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Background

Frailty, a measure of physiologic reserve, is associated with increased mortality, disability, and postoperative complications. Older adults undergoing colorectal surgery are at increased risk. Traditional frailty screening may miss geriatric domains that meaningfully influence recovery. The Age Friendly Health System's 4Ms framework – What Matters, Mobility, Mentation, and Medications – helps identify needs not captured during a routine surgical evaluation.

Case

An 88-year-old woman with recently diagnosed rectal cancer and history of fractures presented for preoperative frailty assessment. She lived alone, had limited social support, and feared losing her independence while she pursued life extending treatment. She was deemed prefrail via the Fried's Frailty Criteria. Cognitive testing showed deficits in domains critical for managing ostomy, and the patient was at elevated risk for deconditioning and delirium. The patient could not afford private caregiver support. Her primary support, a friend, was unable to perform the fine motor tasks required for ostomy management. Discharge to subacute rehabilitation (SAR) was planned.

Using the 4Ms, a preoperative plan of prehabilitation, preselection of SAR, an eye exam, deprescribing high risk medications and ostomy education was completed. Advance care directives and health care power of attorney documents were completed. The postoperative course was uncomplicated; after SAR the patient returned home independently. During the follow up visit, decreased lower extremity strength prompted referral for physical therapy and recommendations for osteoporosis treatment.

Discussion

For adults with cancer, concerns over physical disability, loss of independence, and limited caregiver support highlight the importance of comprehensive assessment before colorectal surgery. The American Society of Colon and Rectal Surgeons guidelines emphasize prioritizing frailty over chronological age in treatment decisions. A focused evaluation targeting geriatric vulnerabilities improves outcomes in older adults.

Conclusion

Pairing the 4Ms with frailty assessment provides a comprehensive preoperative evaluation and supports individualized planning to improve post-operative recovery in older adults. It identifies geriatric specific risks related to key domains. This highlights the framework's importance in optimizing outcomes in vulnerable populations.

C11 Resident Presentation

Wasting Away: An unexpected cause of unexplained weight loss

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Background: Unintentional weight loss is a common geriatric syndrome with a broad differential diagnosis. A thorough history and exam alone can often identify predisposing and precipitating factors, though additional testing may be warranted if the cause is unclear. Here we present a rare but important case to consider in a patient with progressive weight loss.

Case: An 80-year-old male with history of paroxysmal atrial fibrillation, CKD3a, hypertension, and hyperlipidemia initially presented to a geriatric's clinic for unintentional weight loss, occasional gastroesophageal reflux, and left hip stiffness. He weighed 139lbs (BMI 19) on presentation, having lost 25lbs over 3 years. Prior recommendations included new protein supplements, avoiding restrictive diets, and deprescribing diuretics. Despite making these changes, he continued to lose weight.

He denied any problems with food access, dysphagia, or any associated symptoms. He had recently separated from his spouse, raising suspicion for unintended dietary changes, and was counseled to keep a food diary and see a nutritionist. Lab workup was unremarkable. His routine cancer screening was up to date. Further evaluation with CT chest/abdomen/pelvis showed gastric wall thickening which led to an upper endoscopy revealing gastritis and *H. pylori*.

Despite treatment of these, he progressively lost weight down to 119lbs the following year (BMI 16). Around that time, about 14 months after initial presentation, he endorsed worsening left lower extremity stiffness and several falls. Exam revealed a stiff gait, 4/5 strength on left ankle and hip flexion, right hand fasciculations, and absent Achilles reflexes. Electromyography testing was consistent with

motor neuron disease and he was diagnosed with Amyotrophic Lateral Sclerosis (ALS) and referred to a multidisciplinary ALS clinic.

Conclusion: ALS was difficult to recognize in this patient with nonspecific symptoms and competing explanations for his weight loss. With nonmotor features—including cognitive changes and unintentional weight loss—present in 30-50% of patients with ALS at the time of diagnosis, this condition should be considered on the differential if comprehensive assessment is unrevealing.

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C12 Resident Presentation

Hemolysis Harms and Medication Monitoring: A Case Study

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Background: Geriatric populations are at increased risk for medication adverse effects due to age-related changes in pharmacokinetics and pharmacodynamics. These include decreased hepatic renal clearance as well as increased CNS receptor sensitivities (e.g., heightened reactions to well-known classes such as anticholinergics). A less commonly discussed adverse effect is hemolytic anemia secondary to oxidative stress. Classically associated with G6PD deficiency, dapsone induced hemolytic anemia has also been documented in patients with normal G6PD activity, specifically in transplant recipients.

Methods: This case describes a 78-year-old with longstanding symptomatic atrial fibrillation who suffered hemolytic anemia following dapsone exposure despite normal G6PD activity.

Results: The patient had undergone two ablation procedures, multiple direct current cardioversions, and several trials of antiarrhythmic medication, including propafenone, metoprolol, dofetilide, and amiodarone. After a 6-week trial of amiodarone, symptoms and images for amiodarone pneumonitis prompted pulmonary evaluation and subsequent steroid therapy. The patient received dapsone prophylaxis for *Pneumocystis pneumonia* due to a sulfonamide allergy. After one month of dapsone therapy, she was seen in the clinic for fatigue and jaundice. Laboratory results as shown, were consistent with nonimmune mediated hemolytic anemia. Discontinuation of dapsone resulted in improvements in laboratory markers.

Conclusion: Older adults are vulnerable to a range of medication side effects, including hemolytic anemia in the context of oxidative stress. In this case, close follow-up led to efficient identification of an unexpected side effect. The case highlights the importance of close monitoring in older adults with complex medical histories, as medical therapies intended to treat may result in unexpected harm.

Test	Result	Reference/Flag
WBC	10.6 x 10E3/dL	WNL
RBC	3.18 x 10E6/dL	Low
Hemoglobin	10.7 g/dL	Low
Hematocrit	34.0%	WNL
MCV	106.9 fL	High
MCHC	31.5 g/dL	Low
RDW	22.7%	High
Platelets	193 x 10E3/dL	WNL
Reticulocyte %	8.3%	High
Reticulocyte Count (Abs)	0.26 x 10E6/dL	High
Immature Reticulocyte Fraction	28.6%	High
LD	402 U/L	High
Haptoglobin	<30 mg/dL	Undetectable
DAT	Negative	
G-6-PD Activity	16.0 U/g Hb	Normal
INR	2.5	High
Protime	37.5 sec	High

C13 Resident Presentation

Hip Swap That Broke The Brain: A Perphenazine Plot Twist

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Background

Perphenazine (PPZ) is a first-generation antipsychotic (AP) historically used to treat depression, but now rarely prescribed long-term due to extrapyramidal symptoms and adverse cognitive effects. Abrupt discontinuation may precipitate neuropsychiatric symptoms in older adults with multimorbidity undergoing surgery. We present a case of postoperative delirium likely triggered by PPZ withdrawal.

Case

An 80-year-old woman with hypertension, hyperlipidemia, depression, osteoarthritis, and a history of left-sided breast cancer (status post chemoradiation in 2015) was admitted for elective right total hip arthroplasty. She had taken PPZ 12 mg nightly for 40 years for depression and had previously developed confusion when attempting to taper. PPZ was held perioperatively. On postoperative day (POD) 1, she developed anxiety, restlessness, intermittent inattentiveness, and fluctuating orientation. Precipitating factors included poorly controlled postoperative pain, sleep deprivation, opioid-related neurotoxicity (20 mg oxycodone in 24 hours), and potential AP withdrawal given PPZ's short half-life of 9–12 hours. Non-pharmacologic delirium management strategies were initiated, oxycodone was switched to tramadol to reduce opioid-related central nervous system effects, and PPZ was resumed. Her cognition steadily improved and returned to baseline by POD 3. She was discharged with close outpatient psychiatric follow-up to reassess long-term PPZ use and explore safer deprescribing strategies.

Discussion

Older surgical patients on chronic AP therapy are vulnerable to complications from abrupt medication interruptions. Withdrawal-related delirium is often under-recognized and can be mistaken for pain, opioid effects, or routine postoperative cognitive changes. This case highlights the critical role of geri-centric perioperative medication reconciliation to maintain essential neuropsychiatric therapies, along with interdisciplinary collaboration when determining inpatient continuation or deprescribing during transitions of care. Prompt recognition of withdrawal-related delirium is critical to prevent functional and cognitive decline and avoid prolonged hospitalization in older adults.

C14 Resident Presentation

The Heart Takes the Blame: Deconditioning Masquerading as HFpEF

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Background

Dyspnea and bilateral leg swelling are common presenting symptoms in older adults and often prompt evaluation for heart failure. However, overlapping conditions such as chronic venous stasis, obesity, and deconditioning can mimic HFpEF and lead to unnecessary treatment. This case highlights the importance of functional assessment and cautious diagnostic reasoning before labeling older adults with heart failure.

Case

A 78-year-old man with hypertension, hyperlipidemia, obesity, and chronic venous stasis dermatitis presented with progressive shortness of breath and bilateral lower extremity swelling. He denied chest pain, orthopnea, or paroxysmal nocturnal dyspnea. Physical examination revealed soft bibasilar crackles, 1+ bilateral lower extremity edema, and chronic skin changes consistent with venous stasis. His NT-proBNP was

normal. Chest X-ray showed no pulmonary edema, pleural effusion, or pneumothorax. A transthoracic echocardiogram performed one month prior revealed normal systolic and diastolic function (LVEF 55–60%). Despite these findings, with an H2FPEF score of 5 (83% probability), he was started on furosemide and empagliflozin. Within 4 days, he developed acute kidney injury, and his creatinine increased from 1.7 mg/dL (at baseline) to 2.1 mg/dL, prompting discontinuation of both medications. Physical therapy evaluation demonstrated significant deconditioning and exertional intolerance. With daily ambulation and progressive mobility training, the patient's dyspnea and edema improved. Repeat labs after discontinuation of diuretics showed resolution of AKI.

Discussion

This case underscores how deconditioning and chronic venous stasis can mimic the presentation of HFpEF in older adults. Careful review of objective cardiac testing, attention to functional status, and cautious interpretation of physical findings are essential to avoid diagnostic anchoring. Overdiagnosis of HFpEF may expose patients to unnecessary pharmacologic therapy and complications such as iatrogenic AKI. Early mobilization and physical therapy should be prioritized to address deconditioning and improve outcomes. Incorporating functional and mobility assessment into the assessment of older adults with dyspnea and edema may reduce iatrogenic complications and ensure more accurate diagnosis and management.

C15 Resident Presentation

Polypharmacy and Poly-provider Case Report Leading to Adverse Outcomes in a Geriatric Patient

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Background

Polypharmacy is common in older adults and results in the administration of medications not clinically necessary. This increases the risk of adverse drug reactions, drug-drug interactions, medication cascades and can contribute to increased falls and cognitive slippage. Polypharmacy can also be a consequence of seeing multiple providers not specializing in geriatrics. Deprescribing is the systematic discontinuation of unnecessary drugs to mitigate the effects of polypharmacy and reduce overall pill burden. This prevents medication cascades by eliminating drugs that do not benefit or may even harm patients to help improve patient health outcomes.

Methods

The University of California Irvine (UCI) SeniorHealth Center provides interprofessional comprehensive care to patients aged 65 years and older, which is delivered by physicians, pharmacists, social workers among other healthcare professionals. This helps identify gaps in care and improve patient health outcomes through critical interventions.

MS is a 72 year old female patient presenting for a pharmacist consultation with mild cognitive impairment, HTN, DM, HLD and urinary incontinence. She reports being seen by multiple specialists and currently takes 11 medications. There are clear discrepancies between the medication list in the chart and the medications brought in during the visit. She has no caregiver available to help with medication management. She is attempting to use a pill box but uses it inappropriately.

Results

As part of the pharmacist consultation, interventions were made to identify adverse reactions and resulting medication cascades. Medication changes were implemented and an alternative medication management system was discussed with the patient and PCP.

Given cognitive challenges, a referral for a home visit was placed to evaluate the home environment.

Conclusion

Given the complexity of the patient case presented, evaluation by a clinical pharmacist was essential in identifying medication-related causes of cognitive impairment and worsening comorbidities.

C16 Resident Presentation

More Than Meets the Mind: Autoimmune Encephalitis with Subtle Neuropsychiatric Manifestations in an Older Adult

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Background: Autoimmune encephalitis is an acute immune-mediated condition causing brain inflammation, commonly presenting with altered mental status, memory loss, personality changes, seizures, and psychosis. (1)

Objective: In geriatric patients, autoimmune encephalitis symptoms are often confused with neurodegenerative dementia or psychiatric disorders.

Introduction: We present a case of a 77YO Caucasian female with anti-LGI1 autoimmune encephalitis presenting with acute changes in mental status, persistent hyponatremia, and increased panic attacks. Symptoms began after a tropical vacation where she developed seasickness, nausea, and vomiting. Upon returning home, she experienced behavioral changes, memory lapses, and confusion.

At an outside hospital emergency department, she was managed for hyponatremia and encephalitis of unknown etiology. Brain MRI revealed a non-expansile, non-enhancing lesion in the right globus pallidus and hippocampus without restricted diffusion; however, she had sustained a brain injury from a motor vehicle accident thirty years prior. Lumbar puncture ruled out bacterial and viral etiologies, but no autoimmune workup was performed. She was discharged with salt tablets and Ativan as needed.

She presented to our emergency department the same day with persistent symptoms. Repeat brain MRI showed increased T2/FLAIR signal in the right hippocampus, concerning for limbic encephalitis. Lumbar puncture yielded antibodies to LGI1. High-dose steroids were initiated empirically for presumed autoimmune encephalitis while awaiting complete autoimmune workup. The patient showed slight improvement by discharge but demonstrated mild residual memory impairment. She will follow with neurology outpatient for neuropsychological testing to guide future management.

Conclusion: Autoimmune encephalitis, particularly limbic encephalitis, can be challenging to diagnose in elderly adults, as it can mimic natural cognitive decline or personality changes seen in neurodegenerative disorders. It is crucial to include this in the differential diagnosis for elderly adults with acute mental status changes, as early intervention is essential to prevent further permanent decline. While more common in men, it should remain on the differential for women presenting with these symptoms. (1).

(1) https://www.neurology.org/doi/10.1212/WNL.96.15_supplement.2587

C17 Resident Presentation

A Quandary: Delirium, Dopamine Agonists or Dementia Causing Psychosis in an Older Adult

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Background: Older adults with synucleopathies such as Lewy Body Dementia (LBD) and Parkinson's Disease (PD) may experience psychosis, and the use of dopamine agonists (DA), hospitalization and multimorbidity can complicate the picture. Our case highlights how careful consideration of the timeline of symptoms and medication effects can guide diagnostic clarity and care plan in a patient with a prolonged admission.

Case: A 64-year-old woman with PD, poliomyelitis in childhood, impaired ADL ability, and multiple falls and fractures presented to the ED with shortness of breath, confusion, visual hallucinations and paranoid delusions. No etiology was identified for dyspnea, but she was treated for a UTI. She had persistent psychosis and fluctuating mentation (disrobing/biting vs. more conversant at times). Psychiatry recommended and adjusted quetiapine, but she often refused this and home

selegiline and ropinirole. Bloodwork and brain imaging remained unremarkable. Guardianship was sought. Geriatrics was involved 4 months into admission. She was more oriented at times, but lacked insight into her limitations, including her lower extremity atrophy, inability to walk, or her psychosis. Old neurology note showed that she had no benefit with tremors or stiffness with carbidopa-levodopa. After conferring with current outpatient neurologist, it was felt that she more likely has LBD than PD. Following the discontinuation of selegiline, tapering of ropinirole, and addition of rivastigmine patch, the psychosis improved, she had stabilization of mentation, was able to sit and talk about exercise, and was discharged to a SNF after 5 months.

Discussion: Patients with Parkinsonism and psychosis can benefit from comprehensive geriatric assessment to investigate reversible causes of delirium, review medications, and reassess the working neurocognitive diagnosis and plan, with multidisciplinary input. Patient's variable acceptance of quetiapine and DA likely led to fluctuating dopamine levels, affecting mentation. DA-induced psychosis is thought to occur in 16% of PD patients. However, these agents do not usually help LBD patients' motor symptoms and may expose them to risks.

Conclusion: When LBD is suspected, it may be prudent to deprecise DA and add cholinesterase inhibitor, after delirium workup, to address psychosis.

C18 Resident Presentation

The Lewy Body Dementia Quetiapine Trap

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Background: Lewy Body Dementia (LBD) patients are extremely sensitive to antipsychotics due to severe dopaminergic pathway loss. In delirium, even "safer" agents like quetiapine can worsen hallucinations, parkinsonism, autonomic instability, and cognitive fluctuations, while also triggering a cycle of dizziness, orthostasis, falls, and rehospitalization that further accelerates delirium and functional decline. Because antipsychotics often cause more harm than benefit in LBD, management should prioritize non-pharmacologic (NPIs) strategies and avoid antipsychotics whenever possible.

Case Description: An 86-year-old man with LBD, HF, CAD, neurogenic bladder, recurrent UTIs, DM2, and a recent fall with vertebral compression fractures presented after another fall with three days of abdominal pain, worsening hallucinations, agitation, and acute mental status change and he was admitted for delirium management. NPIs for delirium were prioritized, including pain control. Due to escalating agitation, quetiapine 12.5 mg was trialed with apparent improvement, though the benefit could not be separated from concurrent NPIs. He was discharged on quetiapine 12.5–25 mg but was readmitted several times within a month with similar symptoms. During a subsequent hospitalization, quetiapine was reduced to 6.25 mg and later discontinued by his PCP as symptoms worsened at home even on low doses, and management shifted toward preventing falls and rehospitalization.

Discussion: This case highlights profound neuroleptic sensitivity in LBD, where even low-dose quetiapine can worsen symptoms and create a downward spiral of delirium and hospitalization. Because LBD involves marked dopamine degeneration, additional dopamine blockade can precipitate abrupt decline. The patient's initial improvement likely reflected NPIs and pain control rather than antipsychotic efficacy, and ongoing exposure contributed to worsening function, ultimately requiring discontinuation. Optimal delirium management in LBD depends on avoiding antipsychotics whenever possible and prioritizing NPIs to prevent iatrogenic deterioration.

Conclusion: Even low-dose antipsychotics/quetiapine can precipitate significant deterioration, emphasizing the need for cautious risk–benefit assessment and prioritization of NPIs strategies in LBD delirium management.

C19 Resident Presentation

A Mysterious Rash Unmasked - Shingles to Ramsay Hunt Syndrome

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Introduction: Ramsey Hunt syndrome (RHS), or herpes zoster ophthalmicus, is a rare complication of varicella-zoster virus reactivation, which can be difficult to differentiate from Bell's Palsy or shingles. RHS is seen more commonly among older adults. Peripheral facial nerve palsy with a vesicular rash is a unique feature of RHS; however, the rash can present in hidden locations such as the ear or in the oral mucosa before, after, or concurrently with the facial nerve palsy. Our case demonstrates a timeline of symptoms and treatment of an older adult with the eventual diagnosis of RHS.

Case Presentation: A 94-year-old female with past medical history of vertigo, atrial fibrillation, and actinic keratosis, who is not up to date on vaccinations, presents to the clinic for "blisters" in the mouth. She first had oral pain. Her dentist noted oral lesions that should be evaluated by her physician. On physical exam, she had an erythematous vesicle rash on the left side of her face, from the corner of her mouth to cheek. There were also white circular lesions on the middle left side of the roof of the mouth and left buccal mucosa. There was no rash noted in her ear. She was diagnosed with shingles and given 10 days of valacyclovir. Soon after, the rashes improved, but she developed a left sided facial droop with decreased left sided hearing. At this point, she was diagnosed with RHS and given prednisone. Her facial droop and rash resolved. She continues to have mild facial postherpetic neuralgia.

Conclusion: RHS is a rare, often painful condition that can significantly affect quality of life. Close follow up is essential to ensure timely diagnosis, monitor progression, and optimize patient outcomes.



(1)-(4) Before antiviral treatment; (5)-(6) Before additional steroid treatment; (7)-(8) Completion of treatment.

C20 Resident Presentation

Risks of Defaulting to Full Code: Case of a 97-Year-Old With Post-CPR Trauma

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Background: In the ED, asking What Matters Most (WMM) improves goal concordant care¹, and the mortality surprise question (MSQ) can aid prognostication in older adults.² Geriatric syndromes such as frailty and multimorbidity increase susceptibility to CPR-related injuries with low likelihood of recovery.

Case: A 97-year-old man with severe aortic stenosis and intraventricular conduction delay, presenting with two weeks of recurrent falls and dizziness, was admitted for acute cystitis. He was listed as full code, but WMM, MSQ, ACP discussion or frailty score was not documented. The next day, he had a VT arrest requiring 20 minutes of ACLS, after which ROSC was achieved. He sustained extensive

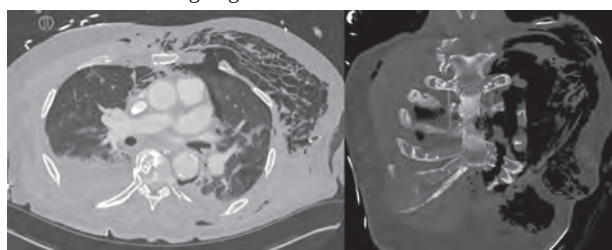
CPR-related injuries, including flail chest and hemopneumothorax, requiring chest tube, mechanical ventilation and vasopressors. Following CTA confirmation of multiple rib fractures, arterial extravasation, pneumomediastinum, and subcutaneous emphysema, care was transitioned to comfort measures after a multidisciplinary family meeting; he died shortly thereafter.

Discussion: In-hospital CPR in nonagenarians carries a high risk of traumatic injury and low likelihood of recovery or survival (11.6%).³ The absence of WMM and MSQ on admission limited early prognostication and insight into the patient's goals and values while he retained capacity. These tools can support risk stratification and guide code status discussions. Defaulting to full code here resulted in invasive, traumatic and non-beneficial interventions that may have misaligned with the patient's values.

Conclusion: Care pathways and practice guidelines should identify high risk older adults and promote proactive goals of care discussions with patients and surrogate decision makers. Early interdisciplinary conversations, even in the ED, facilitate informed, values-based decisions before medical emergencies occurs.

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CT chest shows extensive CPR-related thoracic injuries

C21 Resident Presentation

Relocation-Associated Cognitive Decline in an Older Adult With Dementia

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Background: Relocation in elderly, whether due to medical needs, housing transitions, or social circumstances, is a well-recognized psychosocial stressor. Elderly with pre-existing frailty, dementia, or limited social support are particularly vulnerable. Although transient disorientation is common, some patients experience accelerated cognitive decline, worsening behavioral symptoms, delirium, and depression.

Case Presentation: A 90-year-old man with a history of frontotemporal dementia presented with a progressive decline in cognition and functional status following a major residential relocation. He had no history of tobacco, alcohol, or illicit substance use. Prior to the move, he lived with his family in a suburban, walkable community where he remained fully independent with activities of daily living. He spent much of his time outdoors, gardening, decorating his backyard, and maintained an active social circle with long-standing neighbors. His routine was stable and well structured.

The patient's family planned to relocate for occupational reasons. Although he repeatedly expressed discomfort with the idea of moving, he had to move with his family out of concern for his safety.

He transitioned from his long-time suburban home to a small apartment in the center of a busy city. Within weeks, his family observed changes in his behavior, he became less talkative, developed insomnia, and was often miming gardening motions on the bedroom floor, suggesting attempts to recreate familiar routines from his prior environment.

Over the ensuing months, his cognitive function further deteriorated. He developed increasing disorientation, difficulty recognizing

the new living space, and episodic failure to recall the names of close family members. He experienced episodes of nighttime confusion. Despite previously being fully mobile, he became progressively less active and eventually required assistance with ambulation. By the end of the second year he was largely bedridden with profound functional and cognitive decline.

Discussion: This case suggests that relocation may contribute to faster cognitive and functional decline in older adults with dementia. It reinforces the geriatric principle of "Matters Most," emphasizing the importance of honoring an older adult's preferences. When moves are unavoidable, close follow-up and coordinated support may help detect early changes and possibly prevent further decline.

C22 Resident Presentation

Treatment of recurrent complex cystitis versus asymptomatic bacteriuria in a patient with major neurocognitive disorder

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Background

It is difficult to differentiate cystitis from asymptomatic bacteriuria in older adults with major neurocognitive disorders due to limitations in eliciting symptoms such as dysuria, hematuria and urinary frequency. In the absence of objective data such as fever or hemodynamic instability, there is a tendency to rely on altered mentation and delirium as a symptom of cystitis. The Infectious Disease Society of America recommends against using delirium in isolation as a reason to prescribe antibiotics for bacteriuria and advises observation and investigation into alternate causes.¹

Methods

Case report of an older adult residing in a long-term care facility.

Results

An 84-year-old with a past medical history of atrial fibrillation, hypertension, hyperlipidemia, osteopenia, type 2 diabetes, history of cerebrovascular accident with residual right-sided hemiparesis, major neurocognitive disorder (vascular type) lives at a long-term care facility. From January of 2023 to January of 2025, this patient had 14 urinalyses performed and greater than 10 antibiotics courses of oral cephalosporins. Most of this testing was done for symptoms reported as hallucinations, delusions and altered mentation while patient remained afebrile, hemodynamically stable and without dysuria or suprapubic tenderness. Some episodes had reported urinary frequency. Most urine cultures resulted in *Klebsiella* species or *E. coli*. For recurrent cystitis, the patient was started on prophylactic methenamine hippurate before transitioning to nitrofurantoin then trimethoprim-sulfamethoxazole after urology consultation. Unfortunately, the patient developed erythema multiforme related to trimethoprim-sulfamethoxazole use and now is on fosfomycin. Since being on prophylaxis, the number of urinalyses collected has decreased.

Conclusions

This case demonstrates the importance of judicious use of urinalysis screening for patients with isolated delirium without urinary symptoms. Overtreatment of asymptomatic bacteriuria can result in increased antibiotic resistance and unnecessary exposure to antibiotic side effects.¹ If a patient truly has recurrent cystitis with urinary symptoms and bacteriuria antibiotic prophylaxis can be beneficial.

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C23 Resident Presentation

Alzheimer's Disease and Family Dynamics: A Case Study in Favor of Family Medicine-Trained Geriatricians

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Background: Patient is a 79-year old female with a past medical history of hypertension, obesity, and colorectal carcinoma status post colectomy presenting to family medicine clinic with her daughter and granddaughter for reduced food intake and mental status changes. This patient had recently been diagnosed with Alzheimer's Disease, had begun cohabitation with her family due to progressive cognitive decline, and her daughter had achieved power of attorney status. This case study highlights how family medicine training uniquely equips geriatric physicians to provide full-spectrum, multidisciplinary, and family-centered care.

Methods: This case study is based on a clinical encounter in a family medicine clinic with history supplemented by family members and a comprehensive medical evaluation.

Results: Our patient presented with her family for reduced food intake and mental status changes in the setting of recent Alzheimer's Disease diagnosis. Full workup was negative including reversible causes of altered mental status as well as source of reduced food intake including recurrence of gastrointestinal neoplasm or primary dysphagia. Questioning into the family's overall well-being demonstrated significant caregiver burden and need for intervention. The family was connected with therapy and supportive resources, illustrating how continuity across generations facilitates early recognition and management of caregiver strain. The patient was prescribed mirtazapine for weight gain and sleep, and the family reported improved adjustment to the demands of caregiving.

Conclusions: This patient's symptoms were most consistent with progression of Alzheimer's Disease. With a family medicine perspective and emphasis on continuity, the primary care physician was able to address both the medical needs of the patient as well as the social and emotional demands placed on the family. This case study highlights the contribution of a family medicine perspective as it pertains to a lifespan orientation, behavioral components of care, shared decision-making, and a community mindset. Although this patient presented late in the onset of her disease pathology, the implications of a long-term primary care relationship as it pertains to both preventive medicine and end-of-life care cannot be overstated.

C24 Resident Presentation

Interdisciplinary Delivery of Basic Ambulatory Care to Underserved Populations in Tecate, Mexico

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Purpose

To expand delivery of basic ambulatory and preventive care to underserved residents of Tecate, Mexico, while fostering interprofessional collaboration and community engagement among healthcare professionals and students.

Methods

The outreach clinic operates in Testerazo, a rural community of fewer than 500 residents. Once a month, undergraduate volunteers from the University of California, Irvine (UCI) Flying Samaritans chapter travel with volunteer physicians, dentists, and a pharmacist to provide free healthcare services. The clinic serves men, women, and children of all ages. Services include blood pressure and glucose screenings, dental cleanings and fillings, medication counseling, and coordination with a local laboratory for diagnostic testing. Medication supplies are maintained through ongoing donations that support treatment of both chronic and acute conditions. Patient demographics and service volumes are recorded to assess community reach and evolving healthcare needs.

Results

The clinic has provided preventive and therapeutic services to a diverse, multi-age population. Monthly visits typically serve 6 to 30 residents, most commonly addressing hypertension, diabetes, infections, and dental concerns. Early findings show increased patient awareness of blood pressure and glucose management, improved access to preventive dental care, and greater engagement with healthcare services. Interdisciplinary collaboration among providers and students has strengthened care coordination and efficiency while enhancing the educational experience for volunteers. Community feedback indicates high satisfaction and appreciation for consistent, compassionate care. Repeat visits and growing participation reflect sustained community trust and reliance on clinic services. Ongoing data collection aims to assess patient outcomes, service utilization patterns, and quality improvement opportunities to promote sustainability and clinical impact.

Conclusion

This project demonstrates the value of a collaborative learning model in improving access to care for underserved communities. Through consistent outreach and teamwork, the clinic has built trust and continuity within the community. Continued evaluation will guide service expansion, strengthen partnerships with local providers, and support long-term sustainability and improved health outcomes in Tecate.

C25 Resident Presentation

The VA Frailty Index Predicts Fracture Risk in Women who Start Bisphosphonate Therapy

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BACKGROUND

The Veterans Affairs Frailty Index (VA-FI) provides a scalable, objective measure of frailty using electronic health record (EHR) data. The VA-FI has demonstrated strong construct and predictive validity in Veteran cohorts, but its predictive validity in older women has been less studied. Our study examined whether the VA-FI predicts fracture risk in older women initiating bisphosphonate (BP) therapy for osteoporosis.

METHODS

A retrospective cohort study was conducted using EHR data from a US healthcare system. Women aged 65-84y who initiated oral bisphosphonate (BP) therapy during 2010-2015 were identified. Baseline frailty was assessed using the VA-FI. Incident hip, proximal humerus, and wrist fractures were ascertained during 3 year follow-up. Cox proportional hazard models estimated hazard ratios, adjusting for age, race/ethnicity, smoking, BMI, and time-updated BP adherence ($\geq 50\%$ per quarter). Fine-Gray analyses were also conducted to account for competing mortality.

RESULTS

Among 27,272 women (mean age 73 $\pm$ 6 years; 68% White, 3% Black, 12% Hispanic, 17% Asian) who initiated BP therapy, 52% were non-frail, 29% pre-frail, 12% mildly frail, 5% moderately frail, and 2% severely frail. During 3 year follow-up, there were 479 hip fractures, 365 proximal humerus fractures, and 549 wrist fractures. The adjusted hazard ratios for [hip/humerus/wrist] fractures showed [1.9/1.8/1.3]-fold higher fracture risk for Pre-Frail, [2.3/2.5/1.5]-fold higher fracture risk for Mildly Frail, [3.3/2.6/1.8]-fold higher fracture risk for Moderately Frail, and [4.7/5.1/2.7]-fold higher fracture risk for Severely Frail, respectively, when compared to Not Frail (reference). These results were largely unchanged with Fine-Gray analyses.

CONCLUSION

In women who initiated oral BP therapy, Greater frailty (as defined by the VA-FI) was independently associated with increased non-vertebral major osteoporotic fracture risk. Moderate frailty was

associated with 2-3-fold higher risk and severe frailty was associated with 3-5-fold higher risk. Our findings support the prognostic value of the VA-FI for fracture outcome in women initiating osteoporosis therapy. These findings also suggest that frailty assessment and management should be investigated as a possible intervention for fracture prevention.

C26 Resident Presentation

Development & Evaluation of a Novel Geriatric Neurology Elective

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Background: Limited geriatric educational opportunities exist for medical students. We developed the Aging Brain Elective, a novel multidisciplinary elective blending clinical experiences across neurology, geriatrics, geropsychiatry, and neuroradiology, to address this crucial educational gap. Objectives of the elective include learning to take a detailed history and perform a neurological exam for adult patients with cognitive impairment, as well as learning to evaluate, treat and counsel patients with neurocognitive disorders.

Methods: Quasi-experimental, quality improvement study with pre- and post-test design. Participants (N=8) were fourth year medical students at a medical school in the southeastern US. Students completed a brief survey prior to and following completion of the two-week elective to assesses knowledge and confidence related to care of older adults with cognitive impairment.

Results: Participants were predominantly Asian (N=4) and White (N=3) and all were female (N=8). Most participants (N=7) had little to no experience interacting with older adults with cognitive impairment prior to the elective. Confidence in conducting a thorough history from patients with cognitive impairment increased from 62.5% (N=5) of students reporting a little bit of confidence pre-course to 75% (N=6) reporting quite a bit of confidence post-course. There was also an increase from moderate (N=5, 62.5%) confidence to quite a bit of confidence (N=6, 75%) in interacting with family members of patients with cognitive impairment. Students also reported feeling extremely confident in administering cognitive assessments (N=6, 75%) and quite a bit more confident performing a neurological exam (N=7, 87.5%) after the elective. Qualitatively, students described a better understanding of differentiating normal aging from cognitive impairment and feeling better equipped to coordinate care among interdisciplinary specialties.

Conclusions: With the rapidly aging population, it is important to provide exposure to the care of older adults in medical school curriculum. Preliminary data from this study indicate increased knowledge and confidence surrounding care of the aging brain. Creation of similar, innovative electives at other medical schools is vital to provide learners with the appropriate skillset to care for the aging population.

C27 Resident Presentation

From intractable headache to abdominal pain: A Case of Valproic acid-induced pancreatitis in an Older Adult

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Background:

Valproic acid (VPA) is widely used for epilepsy, bipolar disorder, and migraine prophylaxis. Although effective and generally well tolerated, it has been associated with several serious adverse effects, disproportionately affecting older adults. Polypharmacy, multimorbidity, and age-related pharmacokinetic changes increase vulnerability to medication toxicity.

Methods:

We describe a case of VPA-induced pancreatitis in an older patient, highlighting the importance of early adverse effects recognition.

Results:

67-year-old woman with refractory migraine presented with 2 days of epigastric pain radiating to the back. Exam was remarkable for bilateral upper-limb kinetic tremor. Laboratory findings showed a lipase of 1,000 U/L; computed tomography of the abdomen showed pancreatic edema, confirming acute pancreatitis. She had a previous cholecystectomy and endorsed no alcohol use. Other common etiologies were excluded. She received appropriate management. Upon medication list review, it was found that VPA was introduced six months earlier for migraine prophylaxis with a recent dose increase ten weeks ago. The patient reported that tremors started eight weeks ago. VPA was discontinued. Within the following days, symptoms improved, and tremors subsided.

Discussion/Conclusion:

Drug-induced pancreatitis accounts for less than 2% of all cases. Older adults are particularly susceptible to adverse reactions, and drug-induced pancreatitis should be considered when no clear etiology is identified. In this case, VPA-induced tremor preceded pancreatitis, and it can be argued that recognizing this side effect could have prompted drug discontinuation and potentially avoided the episode of pancreatitis. Due to the high prevalence of polypharmacy in geriatric patients, routine counseling on adverse effects and active monitoring are essential. Although not included in the 2023 Beers Criteria as a drug to avoid, VPA warrants caution in older adults due to its narrow therapeutic window, neurologic side effects, and risk of serious, unpredictable complications such as pancreatitis. This case underscores the importance of close medication review, early recognition of new symptoms, and shared decision-making when prescribing potentially toxic agents to older adults to promote awareness and appropriate action if present.

C28 Resident Presentation

Note-ably More Comprehensive: Using Consult Note Templates to Train Residents to Think Like Geriatricians

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Background

The Geriatrics 5 Ms—Mind, Mobility, Medications, Multi-Complexity, and Matters Most—are used to think of complex older adult patients more holistically. Teaching the 5 Ms in a primary care workshop increased learner self-efficacy. This workshop introduced an EMR template based on the 5 Ms, but the educational impact of using such templates on resident learning has not been studied.

Methods

We created a note template with HPI and assessment/plan organized by the 5 Ms. This template was used by all Internal Medicine PGY1s on a Geriatrics consult rotation at a large academic medical center in the mid-Atlantic. All interns on the rotation from February–November 2025 received an anonymous survey on their self-rated ability to think holistically about their patients, manage complex medical needs, and recall the Geriatrics 5 Ms. All faculty on the Geriatrics consult service received an anonymous survey on learner incorporation of Geriatrics-specific information into their presentations and management. Agreement with survey statements was analyzed by percentage. Residents were asked to list as many of the 5 Ms as possible, and answers were scored to determine the percentage of residents who were able to correctly list $\geq 4/5$ of the 5 Ms.

Results

The resident survey was sent to 52 interns, and 18 responded (34.6%). All surveyed residents felt that using the 5 Ms note template helped them think about their patients more holistically and consider

what was important to their patients. Most (94%) felt that the template helped them better manage their patients' complex medical needs. Some (61%) felt that using the 5 Ms note template took more time than a traditional note. 11% found it difficult to use. Only 28% of residents were familiar with the Geriatrics 5 Ms prior to the rotation, but 78% were able to name $\geq 4/5$ of the 5 Ms by the end of the rotation.

The faculty survey was sent to 8 attendings, and 7 responded (88%). All surveyed faculty reported that interns incorporated more Geriatrics-specific information into their presentations and management after using the 5 Ms template. 71% of faculty reported an increase in learners' ability to discuss mobility and matters most.

Conclusion

Using a 5Ms-based note template enhanced residents' ability to approach geriatric patients holistically and strengthened understanding of core geriatrics concepts, as confirmed by self-report and faculty feedback.

C29 Resident Presentation

Exploring Age-Friendly Care Together: Integrating the 4Ms Into Resident Education Through Paired Learning With Older Adults
H. R. O'Hagan, J. Graupner, R. Kroplewski, K. Thompson. *Internal Medicine, University of Chicago, Chicago, IL.*

Background:

Internal medicine residents often receive limited geriatrics training despite caring for an aging population. The Age-Friendly Health Systems 4Ms framework—What Matters, Medications, Mentation, and Mobility—offers a practical structure for high-quality geriatric care. To address educational gaps, we developed an interactive workshop pairing internal medicine residents with local community-dwelling older adults to practice discussing and documenting the 4Ms.

Methods:

Residents participated in a single-session, small-group workshop during which they interviewed local older adults using a standardized 4Ms worksheet. Following the workshop, participants completed a retrospective pre/post self-assessment rating their understanding of the 4Ms and Age-Friendly Care principles. Changes in understanding were analyzed using the Wilcoxon signed ranks test.

Results:

A total of 30 residents participated in the workshop. Retrospective pre/post ratings demonstrated a significant improvement in understanding of Age-Friendly Care and the 4Ms (Wilcoxon signed ranks test, $W = 3.0$, $p < 0.001$). Residents also expressed strong positive attitudes toward Age-Friendly principles: nearly all agreed that the 4Ms are important for person-centered care of older adults (median = 5 [IQR 5–5]; 97% rating ≥ 4) and that all future medical providers should learn about Age-Friendly Care (median = 5 [IQR 5–5]; 100% rating ≥ 4). In contrast, 53% of residents rated their prior geriatrics-focused training as neutral or insufficient (median = 3 [IQR 2–4]), highlighting an educational gap addressed by the workshop. Qualitative comments noted enthusiasm for connecting with older adults and the value of practicing real-world 4Ms conversations.

Conclusions:

This workshop is a feasible and effective method for integrating Age-Friendly/4Ms education into residency training. Partnering with older adults in local senior living communities created a mutually beneficial experience: older adult participants left with a 4Ms-based tool to guide future care decisions, while residents gained real-world practice learning and applying the 4Ms. Future work will focus on expanding the workshop and evaluating resident retention and application of the 4Ms in clinical practice.

C30 Resident Presentation

Integrating Geriatrics Principles into Surgical Training: A Pilot OSCE for General Surgery Residents on Delirium and Informed Consent in Older Adults

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Background:

General surgery residents receive limited formal instruction on geriatric principles despite the growing numbers of older adults who will likely require surgery. To address this gap, we developed and piloted an Objective Structured Clinical Examination (OSCE) to teach and assess communication and decision-making skills for surgical care of older patients. This model offers a replicable educational intervention for future resident cohorts.

Methods:

Four PGY-2 general surgery residents participated in a two-station geriatrics focused OSCE. Station 1: Management of hypoactive delirium in a hospitalized older adult. Station 2: Conducting informed consent for urgent surgery in a frail older patient. Each resident interacted with standardized patients (SPs) who completed structured evaluations using a 3-point scale: 1= Not Done, 2= Partly Done, and 3= Well Done. Domains assessed included communication, patient-centeredness, and elements of informed consent. Performance was summarized descriptively to identify strengths and learning needs.

Results:

SP evaluations demonstrated strong communication and empathy skills, with all residents rated "Well Done" on allowing patients to speak uninterrupted, clarifying understanding, and demonstrating concern and respect. In the informed consent station, 100% of residents clearly explained the diagnosis and procedure, but only half comprehensively addressed general procedural risks, and none explicitly covered procedure-specific risks. While all residents discussed treatment alternatives, only 25% fully articulated the downsides of nonoperative management. Verification of patient comprehension was inconsistently demonstrated (25% "Well Done"). These results highlight both communication strengths and persistent gaps in informed consent and shared decision-making in older adults' surgical care.

Discussion/ Conclusions:

This pilot OSCE demonstrated the feasibility and value in integrating geriatrics focused simulation into surgical education. While residents showed strong communication skills, opportunities remain to enhance patient education and shared decision-making. Key lessons include the importance of targeted teaching on complex consent discussions including that cognitive impairment may affect decision making capacity. This model is replicable and provides a foundation for ongoing geriatrics integration in surgical training.

C31 Resident Presentation

Simulation Education on Disability and Delirium

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By 2030, 20% of the developed world will be aged 60 or older (1). This group is at higher risk for disability and delirium (2). Delirious patients have increased mortality (10% increase at 30 days, and 70% increase at 6 months) (3, 4). Delirium is often missed and may be preventable in 40% of cases (4). We designed a simulation of delirium and disability and measured its impact on learners.

Methods

The study has a Pre-Test/Post-Test Quasi-Experimental design. There were 9 participants: resident physicians and students of medicine, pharmacy, and nursing. Disability was simulated via Geriatric Sensory Impairment Kit from Reality Works. Kiersma-Chen Empathy Scale was used to measure empathy (4). 6 multiple choice questions were used to measure knowledge. Data was assessed with the Shapiro-Wilk Test and paired t-test.

Results

The average total score for the empathy scale increased significantly from 83.89 to 91.89 (p-value 0.014). Scores on individual questions on average improved from 5.59 to 6.13 (p-value 0.0003). Average scores on cognitive domain went up from 5.86 to 6.46 (p-value 0.0021). In the affective domain, the average score went up from 5.19 to 5.63 (p-value 0.043). In knowledge-based questions, the percentage correct rose from 52.96 to 62.72 (p-value 0.014) post-simulation.

Conclusions

The simulation improved empathy and knowledge of learners. Sample size is a major limitation. The data was collected across 3 different simulation events, so there may have been variability in execution. The Empathy Scale that we utilized is not specific to the geriatric population. Four of the questions on the empathy scale are phrased negatively and may not have been recognized as such by participants. This could have skewed the data. We will continue to collect data from each event to assess trends.

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C32 Resident Presentation

Geriatrics Education Innovation for internal medicine residents

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Introduction:

Older adults comprise a substantial portion of internal medicine (IM) inpatient and outpatient care and often present with atypical symptoms, multimorbidity, and vulnerability to functional decline, delirium, falls, and medication-related harm. IM residents serve as frontline providers but frequently lack structured geriatric training. To address this gap, we developed a resident-focused educational intervention grounded in the Age-Friendly Health Systems 4Ms Framework (What Matters, Medications, Mentation, and Mobility) to improve outpatient geriatric care competency.

Methods:

We created a comprehensive, visit-based 4Ms curriculum for IM residents incorporating brief didactics, a universal 4Ms clinical checklist, and focused modules on delirium, dementia, polypharmacy, falls, mobility, and common sensory, urinary, and bowel issues. Teaching emphasized practical skills: eliciting What Matters; applying Beers Criteria to identify high-risk medications; conducting quick mentation assessments (CAM, brief cognitive screens); and performing gait and fall-risk evaluations. Resources included algorithms for deprescribing, dementia screening indications, and fall-prevention strategies. Residents applied the checklist at routine clinic visits to promote consistent age-friendly care.

Results:

Implementation improved residents' recognition of high-risk geriatric presentations and increased the frequency of structured geriatric assessments at primary care visits. Learners reported greater confidence in medication reconciliation, identification of delirium, screening for dementia, and addressing falls and mobility concerns. Faculty observed more reliable documentation of goals, proxies, and advance directives, and more frequent deprescribing discussions.

Discussion:

Embedding the 4Ms into daily IM practice provided a simple yet powerful framework for geriatric care. The structured checklist and focused teaching created a shared mental model that improved consistency, reduced missed risks (e.g., hypoactive delirium, fall hazards, high-risk drugs), and highlighted reversible contributors to cognitive decline. Integrating What Matters discussions fostered patient-centered decision-making and improved alignment between care plans, safety, and patient values. Small, consistent actions, such as medication review, fall screening, delirium prevention, and attention to What Matters, meaningfully improve outcomes for older adults and equip IM residents to provide safer, more person-centered care.

C33 Resident Presentation

The extension for community healthcare outcomes:

a collaborative technology based approach to understanding the unique challenges of geriatric patients

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In an era where technology is integral to daily life, modern medical education must harness its full potential to enhance learning. The extension for community healthcare outcomes aims to transform education by using videoconferencing and a multidisciplinary model. Healthcare providers, ethicists, students, and experts form a virtual community of practice which enables real-time knowledge sharing and mentorship. In this "all learn, all teach" model, participants engage in case-based discussions and expert-led presentations, fostering a dynamic, inclusive environment for learning. The project addresses the complexities of geriatric care, where comorbid conditions, cognitive decline, functional impairments, and socioeconomic factors are often overlooked in traditional training. Primary care providers and trainees, especially in rural or underserved areas, may struggle to manage these challenges without specialist support. The project bridges this gap by broadening access to specialty knowledge and empowering local providers to deliver high-quality, patient-centered care. One of the key strengths of this project is its focus on case-based learning, where discussing individual cases and sharing practical strategies helps build confidence and competence in managing geriatric syndromes. This collaborative model not only enhances provider expertise but further fosters an understanding of the unique and distinct challenges faced by an aging population. Through this format of learning, family physicians and residents gain the skills needed to provide comprehensive geriatric care, improving population health as the ultimate measure of success. By blending humanism with technology, the extension for community healthcare outcomes sustains the noble traditions of medicine while adapting to society's evolving needs.

C34 Resident Presentation

The Hypo-Potamus in the Room: Refractory Hypokalemia, Hypocalcemia, and Hypomagnesemia from Chronic PPI Use. A Call to Deprescribe in Older Adults.

A. Velasquez, M. E. Wilson. *Internal Medicine, Orlando Health, Birmingham, AL.*

Background:

Among older adults, 10–40% are prescribed proton pump inhibitors (PPIs), and up to one-half of this use is long-term and potentially inappropriate. Chronic PPI therapy is increasingly recognized as a contributor to clinically significant hypomagnesemia, often accompanied by refractory hypokalemia and hypocalcemia, which has been associated with arrhythmias, falls, syncope, delirium, torsades de pointes and sudden cardiac death.

Methods:

We present a case of PPI-induced electrolyte disturbances in an older adult, in which deprescription was a key factor in achieving life-long correction.

Results:

68-year-old woman with hypertension, heart failure, gastroesophageal reflux/Schatzki's ring with prior dilations, and depression presented after a second episode of near-syncopal episode endorsing acute abdominal pain, diaphoresis and nausea. Vital signs were stable. Exam revealed focal lower-quadrant abdominal tenderness without peritoneal signs. ECG showed normal sinus rhythm with mild inferior T-wave inversions and a prolonged QTc; with normal serial high-sensitivity troponins. Chest/abdomen imaging showed no acute pathology. Laboratory showed hypokalemia (3.2 mEq/L), hypocalcemia (8.2 mg/dL), and severe hypomagnesemia (0.6 mg/dL). Medication review revealed chronic pantoprazole use. Given the workup negative for other etiologies, her presentation was attributed to long-term PPI therapy. Pantoprazole was replaced with famotidine. Electrolyte repletion led to normalization within 48 hours and symptom resolution.

Discussion/conclusions:

Magnesium deficiency leads to refractory hypokalemia and hypocalcemia and can precipitate arrhythmias through QT prolongation. Most magnesium is absorbed passively in the small intestine, with a smaller but essential fraction absorbed through the active TRPM6/7 transport pathway. Proton pump inhibitors inhibit TRPM6/7, resulting in chronic hypomagnesemia. In older adults, low magnesium can explain multisystem symptoms such as presyncope, chest discomfort, gastrointestinal dysmotility, chronic pain, and mood changes. Timely recognition of PPI-induced electrolyte disturbances enables clinicians to address the underlying cause rather than treating only multisystem symptoms, thereby preventing unnecessary cardiac, neurological, and abdominal evaluations and reducing morbidity.

C35 Resident Presentation

How a Safe Discharge can be as Crucial as a Coronary Catheterization

A. Velasquez, K. J. Murray. *Internal Medicine, Orlando Health, Birmingham, AL.*

Background:

Safe discharge of older adults after cardiovascular procedures requires a comprehensive, multidisciplinary approach that addresses both clinical and social factors to minimize the risk of adverse events and readmission.

Methods:

We present a case of ineffective safe discharge in an older adult undergoing coronary stenting that resulted in two additional admissions and procedures that could have been prevented, and where a comprehensive geriatric-oriented discharge planning reversed a cycle of readmissions.

Results:

A 67-year-old man with COPD, anxiety, and coronary artery disease underwent a percutaneous coronary intervention (PCI) with diagonal artery stenting. Still, he did not initiate prescribed dual antiplatelet (DAPT) and statin therapy, due to poor understanding and unstable motel-based housing. He returned four days later with chest pain; repeat PCI showed residual stenosis and an occluded secondary obtuse marginal artery, and a second stent was placed. Despite offered shelter options, he declined and again lacked reliable medication access. He re-presented days later with dyspnea and burning chest pain after not taking inhalers or other medications. EKG showed sinus rhythm with no ischemic changes, and symptoms improved with COPD, reflux, and pain management. He also had mild protein-calorie malnutrition, addressed with increased meal portions. Cognitive screening showed preserved orientation but significant anxiety and medication overload, limiting his ability to manage a complex regimen. During the third admission, discharge planning focused on simplifying medications, using teach-back, and involving a trusted friend. This friend obtained medications, confirmed dosing with the team, and secured temporary stable housing. With this coordinated

approach, the patient initiated consistent DAPT, understood his regimen, and attended outpatient cardiology follow-up without further readmissions.

Discussion/conclusions:

This case illustrates how insufficient attention to geriatrics-specific factors, polypharmacy, limited health literacy, anxiety, and housing instability can result in repeated readmissions and critical lapses in adherence after PCI. Stabilization of social supports and intentional medication education, primarily through caregiver involvement, enabled safe transition and prevented further hospitalizations. Early integration of geriatric principles into discharge planning can transform high-risk discharges into successful recoveries.

C36 Resident Presentation

Alcohol and the elderly: senior driving under the influence.

C. PALMIERE. *CURML, UMPT, Lausanne, Switzerland.*

Although the senior population is often mentioned in numerous studies on driving fitness in relation to the possible onset of cognitive disorders, a significantly smaller number of studies consider the issue of alcohol consumption and, with it, the possible involvement of the senior population in traffic violations such as driving under the influence of alcohol.

Considering the increase in the number of seniors with a driver's license in the Western population, and the overall improvement in seniors' health, which allows them to maintain their driving fitness for a long time, it therefore seems necessary to analyze recent data concerning traffic violations involving the senior population, particularly driving under the influence of alcohol, in order to identify the people at highest risk, the most common risk factors, and possible intervention strategies.

The aim of this study was to review senior individuals (men and women aged between 65 and 80 years) who turned to our service between January 2023 and December 2025, in the context of an administrative decision following a traffic violation (driving under the influence of alcohol), for whom the administrative authority required a medical assessment of fitness to drive.

For each of the subjects considered in the study, demographic characteristics, the context and dynamics of the traffic violation, the general physical condition, toxicological analyses aimed at defining alcohol consumption habits, as well as any prescribed psychopharmacological treatments and cognitive status, were examined.

From the preliminary data collected, and as already highlighted by some previous studies on the subject, the importance of using a more specific protocol for the medical assessment of driving fitness in this population emerges, different from that used for the non-senior population. A specific protocol for the senior population must indeed allow for a complete, thorough, and above all systematic investigation, not only of alcohol consumption habits but also of multimorbidities, multiple prescriptions of psychotropic medications, as well as cognitive status with reference to motor vehicle driving.

C37 Resident Presentation

A Case of Hyponatremia presenting with Depressive-like symptoms in an Older Adult

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Background:

Hyponatremia is one of the most frequent electrolyte disorders in older adults, affecting up to 30% of hospitalized geriatric patients. Age-related renal changes, multimorbidity, and polypharmacy increase vulnerability, contributing to neuropsychiatric symptoms and functional decline associated with hyponatremia. Because symptoms overlap with depression, misattribution can lead to delays in diagnosis and worsening sodium imbalance.

Methods:

We present a case illustrating diagnostic challenges in distinguishing hyponatremia from depressive symptoms, as well as the consequences of initiating antidepressants without laboratory assessment in very old adults.

Results:

A 92-year-old woman with mild dementia and alcohol use disorder presented with persistent fatigue, hypersomnia, decreased appetite, and recurrent falls. One week earlier, she was diagnosed with presumed depression and started on duloxetine. History revealed a recent episode of gastroenteritis and continued daily beer intake. On arrival, her mental status was at baseline. Serum sodium was 100 mEq/L, and serum osmolality was 260 mOsm/kg. Urine studies were obtained after initial fluids were administered. She was admitted to the intensive care unit and treated with fluid restriction and salt tablets. Duloxetine was discontinued. Sodium was corrected and, after discontinuation of the antidepressant, was sustained within normal limits, with marked improvement in appetite, activity, and gait stability.

Discussion/Conclusion:

This case shows how hyponatremia can mimic depressive symptoms in older adults, especially those with baseline cognitive impairment. The marked improvement after sodium correction supports hyponatremia as the primary driver of her presentation. The etiology was likely multifactorial, involving low solute intake from alcohol use and recent gastrointestinal losses, with potential contribution from duloxetine. Notably, duloxetine is listed in the 2023 AGS Beers Criteria as increasing the risk of syndrome of inappropriate antidiuretic hormone secretion and clinically significant hyponatremia, underscoring the importance of laboratory evaluation to identify reversible metabolic problems before diagnosing late-life depression and initiating antidepressants in high-risk older adults, to prevent avoidable morbidity in this population.

C38 Resident Presentation**Low Bone Mineral Density is Common in Fractures from High Energy Mechanisms**

J. Zois, S. Hurley, J. Greenwald, N. Lee, A. Harden, A. Agnew, J. Lather, L. Southerland. *The Ohio State University, Columbus, OH.*

Background: Osteoporotic fractures are classically associated with low-energy mechanisms. Current trauma guidelines do not address low bone mineral density (BMD) as a contributory cause in fractures resulting from high-energy mechanisms of injury, such as motor vehicle collisions. The goal of this study was to describe the prevalence of osteoporosis/osteopenia in older adults with thoracic fractures sustained from a high-energy mechanism of injury.

Methods: We performed a retrospective cohort analysis of random patients aged ≥ 60 years in the hospital's trauma databank (2020-2024) who sustained thoracic fractures from a high-energy mechanism of injury. All patients attended a level 1 trauma center and underwent computed tomography chest scans. Injuries from motor vehicle collision, motorcycle collision, or pedestrian struck by a vehicle were included. Thoracic fractures were categorized as rib, sternal, or clavicular. Data elements included demographics and BMD testing results or diagnosis of osteoporosis/osteopenia (either by ICD10 code, by demineralization noted in imaging results, or from provider notes) in the 2 years preceding and/or the 2 years following the injury encounter date. Data was abstracted from the electronic medical record by trained chart reviewers.

Results: The random cohort included 100 patients and 61% (n=61) were men. Their average age was 70.5 years. Within the cohort, 91% (n=91) had at least one rib fracture, 26 had sternal fractures, and 14 had clavicular fractures. Over a third (38%, n=38) had concomitant thoracic vertebral fractures. Diagnosis of low BMD was common overall (35%, n=35) but especially in women (53.8% (n=21)). Formal BMD testing was rarely present within the 4 years of the injury (n=5).

Conclusions: Low BMD is common in older adults with high-energy traumatic fractures, especially women. Our data is limited by the reliance on reported data and the known underdiagnosis of low BMD in men. Optimization of bone health and testing for low BMD should be considered after any fracture, low or high energy-mechanism.

C39 Resident Presentation**Investigating the impact of a frailty-based risk stratification index on outcomes in geriatric patients with rib fractures**

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2. *Division of Biostatistics and Bioinformatics, Department of Pharmacology, Physiology, and Cancer Biology, Thomas Jefferson University - Sidney Kimmel Medical College, Philadelphia, PA.*

Background

As the geriatric population lives an increasingly independent and active lifestyle, they have experienced a corresponding increase in traumatic injuries. Literature suggests that frailty plays a key role in the outcomes of these patients, and the modified 5-item frailty index has recently been shown to be a reliable predictor of morbidity and mortality in trauma. To better identify patients at a higher risk of adverse outcomes, we developed a frailty-based risk stratification protocol for geriatric rib fracture patients.

Methods

This is a single-center, retrospective cohort study conducted at Jefferson Abington Hospital spanning the two years before and after implementation of a rib fracture protocol in 2020. Patients over 65 years old admitted to the ICU with radiographic evidence of isolated rib fracture were the primary population.

Results

A total of 1165 patients met study inclusion criteria (456 pre- and 669 post-implementation). After implementation, more patients were admitted directly to the ICU (36.5% vs 26.5%; $p=0.001$). Injury Severity Score between time periods was comparable (mean 9.5 vs 9.0 respectively). The rate of admission to med/surg level of care with subsequent upgrade to ICU was lower after implementation but not significantly so (6.6% vs 4.6%, $p=0.30$). Mean length of stay was also comparable (4.4 days before, 5.0 days after, $p=0.047$).

Conclusion

There was a statistically significant increase in direct ICU admission after implementing a frailty-based risk stratification index for geriatric rib fracture patients. The protocol appears to have decreased the rate of unplanned ICU admissions, but more data is needed to determine its impact on long-term outcomes.

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C40 Resident Presentation

Association Between Pet Ownership and Incident Dementia: A Systematic Review

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Background

Dementia affects more than 55 million people worldwide, and prevention remains a global priority. Pet ownership is a modifiable factor hypothesized to improve cognitive health, but longitudinal evidence is mixed. We planned a systematic review and meta-analysis to synthesize evidence on the association between pet ownership and incident dementia.

Methods

We searched PubMed, Embase, CINAHL, and PsycINFO. Eligible designs were prospective cohort, case-control, or nested case-control studies in adults without dementia. We included studies reporting on our primary outcome of incident dementia and/or dementia-related secondary outcomes. Two reviewers independently screened, extracted data, and assessed risk of bias. Since studies reporting incident dementia were too few (n=3) and too heterogeneous, we decided to conduct a narrative synthesis rather than a meta-analysis.

Results

We included six studies. Exposures were heterogeneous, including the type of animals and interactions with them. Outcomes spanned conversion from normal cognition to mild cognitive impairment or dementia and worsening neuropsychological trajectories. For the primary outcome, two studies suggested a protective association between pet ownership, especially dogs, and incident dementia, while one study found no significant association. For the secondary outcomes, three studies found that dog or cat ownership, especially with dog walking, was associated with slower cognitive decline, whereas one study reported increased risk of cognitive impairment associated with a broad or non-companion "domestic animal" exposure. Overall risk of bias was moderate to high.

Conclusion

The type of pets and related behaviors may be more critical than ownership alone for preserved cognitive function. Current evidence, though heterogeneous, suggests that while pet ownership, particularly contact with dogs and dog walking, may be associated with healthier cognitive aging, broad or non-companion animal exposure may not confer the same benefit. For clinicians, promoting pet ownership for dementia prevention is premature based on this evidence. Future studies should separate species and behaviors and account for competing risks to clarify when and for whom pet ownership supports healthy cognitive aging.

C41 Resident Presentation

CNS Polypharmacy in Advanced Heart Failure: A Wake-Up Call for Early, Multidisciplinary Deprescribing

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Background

Polypharmacy involving central nervous system (CNS) medications in older adults increases the risk of adverse events, particularly in those with heart failure, where oversedation and delirium may be misinterpreted as decompensation. Deprescribing guidelines provide medication-specific recommendations but do not address the complexity of simultaneously tapering or discontinuing these medications

during hospitalization. Evidence-based principles including early identification, individualized tapering, and shared decision-making, highlight hospitalization as a crucial opportunity for deprescribing and preventing recurrent harm.

Case Description

A 90-year-old male with heart failure, depression, anxiety, and insomnia was admitted with altered mental status. He was obtunded on arrival, and the geriatrics team was consulted for delirium. Medication review revealed polypharmacy: alprazolam, zolpidem, tizanidine, mirtazapine, gabapentin, and intermittent unsupervised clonazepam use. He had been self-managing medications but was unable to confirm regimen, raising concern for mismanagement. Evaluation was negative for other causes, supporting suspicion for polypharmacy-induced encephalopathy. Chart review showed recurrent admissions for heart failure exacerbation complicated by delirium, yet no previous attempts at deprescribing high-risk medications. Geriatrics, Psychiatry, Pharmacy, and Primary teams collaborated. Benzodiazepines were tapered to prevent withdrawal seizures. Tizanidine was continued as-needed given concerns for rebound hypertension and impact on cardiac output. Zolpidem and gabapentin were held. Mirtazapine was continued with plans for close psychiatric follow-up. His mental status improved, and he was discharged to subacute rehabilitation.

Discussion

This case illustrates how unsupervised CNS depressant use can drive recurrent delirium and complicate heart failure management. It also underscores the importance of early Geriatric involvement, through timely identification of polypharmacy, and a multidisciplinary, evidence-based deprescribing strategy to reduce preventable delirium and rehospitalizations among frail older adults with multimorbidity.

C42 Resident Presentation

Preoperative self-assessment of cognition in older patients undergoing elective orthopedic surgery.

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Background:

Postoperative delirium is a significant problem in older adults undergoing elective surgery. The risk varies widely by surgery type, but for elective orthopedic procedures delirium may occur in more than 40% of vulnerable older adults. There are many factors that influence risk of delirium, but evidence indicates that age and pre-existing cognitive impairment are the strongest predictors of post-operative delirium. At our institution, there is not a robust preoperative screen for cognitive impairment and postoperative delirium risk in vulnerable adults undergoing elective orthopedic procedures. The purpose of this quality improvement project was to (1) administer a brief cognitive screening tool, the AD8, preoperatively to older adults undergoing joint replacement surgery and determine if patients with a higher score on this tool were more likely to develop postoperative delirium; (2) assess feasibility of administering the AD8 during preoperative education sessions.

Methods:

Patients aged 65 or older undergoing Joint Academy education session via phone call between 4/2/25 – 6/5/25 prior to elective joint replacement surgery at our institution were asked to complete the AD8 questionnaire during the education session. Questions were read aloud by provider (or interpreter for Spanish-speaking patients) and patient answers were documented directly into REDCap. Descriptive statistics were used to summarize patient demographics and AD8 scores.

Results:

A total of 115 patients completed the AD8 and underwent joint replacement surgery. The mean age of patients was 73.1 years (SD 5.6). Patients were majority female (67.8%). The race and ethnicity groups included were White non-Hispanic (80.9%), Black non-Hispanic (12.2%), and White Hispanic (5.2%). Surgeries included total knee

replacement (58.3%) and total hip replacement (41.7%). Nearly all AD8 administrations were completed in 5 minutes or less (93.9%). A total of 24 patients (20.9%) had an AD8 score of 2 or higher, indicating that mild cognitive impairment was likely present prior to surgery.

Conclusions:

The AD8 questionnaire was able to be administered quickly during preoperative education sessions for elective joint replacement surgery patients. Analysis is ongoing to determine whether AD8 scores were correlated with incidence of postoperative delirium.

C43 Resident Presentation

Clinical characteristics and social needs among hospitalized veterans with the long toenail sign

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Background: Severely long toenails have been posited as a physical representation of diminished physical capacity, cognitive status, and/or social support among older adults, yet little research has characterized individuals with the long toenail sign (LTS). We evaluated the clinical characteristics and structural and social determinants of health (SSDOH) needs of hospitalized veterans with and without the LTS, hypothesizing greater SSDOH needs among LTS+ patients.

Methods: Inpatients at the Boston VA who received a toenail care consult (1/2018-12/2024) were included in this retrospective chart review. Differences in demographic, medical, and SSDOH characteristics between LTS- and LTS+ veterans (hallux nail <2 cm vs. ≥2 cm) were reported using descriptive statistics and standardized mean differences (SMD), with >|0.2|, >|0.5|, and >|0.8| representing small, medium, and large effect sizes.

Results: 44 of 57 patients had a documented hallux nail length and were included in this analysis. LTS+ veterans (n=30/44, 68%) were predominately male (28/30, 93%) and were younger than LTS- veterans (mean age 72.7 vs 80.4 years). Although they had a lower prevalence of medical comorbidities (e.g., T2DM: 33% vs 57%), LTS+ veterans had a higher prevalence of unmet needs across all SSDOH domains (e.g., education access and quality: 30% vs 0%; healthcare access and quality: 43% vs. 29%) (Table 1).

Conclusions: The LTS is associated with social and structural barriers to health among older veterans. LTS+ patients had fewer chronic medical conditions than LTS- patients, which may suggest increased attention paid to the feet of patients with conditions that limit self-care. We recommend incorporating routine foot evaluations into clinical practice and using the LTS as a cue to explore contributing factors and unmet SSDOH needs among older adults.

Table 1: Medical comorbidities and unmet social needs among patients with and without the long toenail sign (LTS)

Characteristic	LTS Absent N = 14*	LTS Present N = 30*	Standardized Mean Difference	95% Confidence Interval
Congestive heart failure	7 (50%)	8 (27%)	-0.49	-1.1, 0.15
Type 2 diabetes mellitus	8 (57%)	10 (33%)	-0.49	-1.1, 0.15
Dementia	5 (36%)	6 (20%)	-0.36	-1.0, 0.28
Number of unmet social and structural health needs	0.7 (0.6)	1.5 (1.6)	0.64	0.00, 1.3
Neighborhood and built environment	2 (14%)	7 (23%)	0.23	-0.40, 0.87
Education access and quality	0 (0%)	9 (30%)	0.93	0.26, 1.6
Healthcare access and quality	4 (29%)	13 (43%)	0.31	-0.33, 0.95
Social and community context	3 (21%)	9 (31%)	0.22	-0.42, 0.86
Economic stability	1 (7.1%)	6 (20%)	0.38	-0.26, 1.0

*Mean (SD); n (%)

C44 Resident Presentation

Clinical Phenotype and Inpatient Outcomes of Elderly Men With Hypogonadism Hospitalized for Hip Fracture: A National Analysis

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Background: Hypogonadism is uncommon but clinically relevant in older men and may influence bone health and physiologic reserve. Its impact among men hospitalized with hip fracture is not well described. We characterized the clinical profile and inpatient outcomes of men with hypogonadism using a national dataset.

Methods: Using the 2019–2022 Nationwide Readmissions Database, we identified men ≥50 years hospitalized with hip fracture. Exposures, comorbidities, and outcomes were defined using ICD-10-CM codes. Outcomes included pneumonia, respiratory failure, acute kidney injury (AKI), venous thromboembolism (VTE), in-hospital mortality, length of stay (LOS), and total hospital costs. Survey-weighted logistic and linear regression models adjusted for age and comorbidities. Significance was defined as p<0.05.

Results: Among ~410,000 weighted hospitalizations, hypogonadism was rare (0.12%). Compared with others, men with hypogonadism were younger (74.0 vs 77.6 yr, p<0.001) and had higher rates of AIDS (1.7% vs 0.4%), leukemia (2.9% vs 0.9%), depression (24.0% vs 13.3%), drug abuse (5.1% vs 2.2%), obesity (12.0% vs 7.2%), hypothyroidism (23.8% vs 12.9%), and other thyroid disorders (2.4% vs 0.8%) (all p<0.01). Osteoporosis (18.8% vs 6.6%) and osteopenia (6.1% vs 2.3%) were more common (p<0.001). Dementia (11.4% vs 23.9%) and tobacco use (11.5% vs 17.0%) were less common (p<0.05).

Adjusted analyses showed no association between hypogonadism and pneumonia, AKI, VTE, or mortality. Hypogonadism was linked to lower odds of respiratory failure (aOR 0.59; 95% CI 0.36–0.97) and to longer LOS (+1.9 days; p=0.026) and higher costs (+\$18,910; p=0.018).

Conclusion: Men with hypogonadism hospitalized for hip fracture represent a distinct clinical phenotype with greater metabolic and endocrine comorbidity and markedly higher bone disease burden. Although hypogonadism was not associated with major complications or mortality, it was linked to greater healthcare utilization. Given their high prevalence of osteoporosis and osteopenia, hypogonadal patients should be monitored closely and prioritized for bone disease screening and management.

C45 Resident Presentation

Ensuring Patient Preferences: POLST Form Management at a Community Based Hospital

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Background

Physician Orders for Life-Sustaining Treatment (POLST) forms ensure that patients' preferences are honored during medical crises or at the end of life. Updated POLST forms can reduce unnecessary care, lessen family distress, and improve continuity across care settings. However, hospitals often fail to provide patients with their original or updated forms at discharge. This study evaluated current practices related to POLST creation, documentation, and patient receipt of their form in a higher-acuity telemetry unit and identified areas for improvement. To support future state- or national-level implementation, we aim to first strengthen and standardize the workflow within our hospital.

Methods

An observational quality-improvement review was conducted in the telemetry units at Pomona Valley Hospital Medical Center. Charge nurses recorded (1) new POLST forms completed upon admission and (2) the number of patients discharged with their original or a copy.

A workflow change involved training the unit secretary to upload POLST forms into the EMR and include originals with discharge paperwork. POLST distribution was compared before and after the intervention, alongside assessments of EMR access, scanner availability, and departmental responsibilities. Race/ethnicity data were collected when available.

Results

Five patients had new POLST forms completed on admission. Only one patient (20%) was discharged with their form because the receiving skilled nursing facility required it. A physical copy was placed in the chart and scanned into the EMR after discharge. The remaining patients did not receive their original or a copy, and no mailed copies were confirmed. Nursing units lacked functioning scanners, preventing real-time upload. Medical Records scans forms only after discharge. Both departments assumed the other was responsible for scanning and distribution, revealing a significant workflow gap.

Conclusions

Despite new POLST forms being completed, most patients are left without the document, risking loss of critical end-of-life preferences across care transitions. Lack of scanners and unclear departmental roles were major contributors. More transparent communication, defined responsibilities, standardized training, and the restoration of point-of-care scanning are needed to ensure patients' wishes are reliably honored.

C46 Resident Presentation, Encore Presentation Utilization Patterns of Hospice Care Among Asian Americans, 2016-2020

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Background: The Asian-American (AA) population is one of the fastest growing minority communities in the US, emphasizing the need to raise awareness of the benefits of hospice care in this population.

Objective: To examine utilization of hospice by AAs and explore trends from 2016 to 2020.

Methods: We used Medicare fee-for-service claims of 2016-2020, for patients whose race was 'Asian/Pacific Islander'. To examine utilization patterns per population, we calculated the average number of hospice stays and length of hospice stays (LOHS). We analyzed these utilization variables by survival status and gender (male/female). Patients with a valid date of death were assigned 'deceased' status. Moreover, we explored state-level variations and examined a 5-year trend of hospice usage by AAs. As a sensitivity analysis, we separated older AAs (aged 65 and above) from younger AAs.

Results: Of 1.89 million AAs enrolled in Medicare in 2016, 35% of the deceased (n=47,651) had at least one hospice stay of an average of 40 days. Proportion of hospice usage among the deceased remained consistent from 2017-2020 (from 38% to 37%). Overall, females stayed longer in hospice than males. At the state level, LOHS varied widely from 11 days (South Dakota) to 106 days (Montana) among the deceased, and 18 days (Wyoming) to 283 days (Alabama) among survivors. From 2016-2020, average LOHS increased slightly for the deceased (from 40 to 42 days). Sensitivity results showed that younger AAs were less likely to use hospice care than their older counterparts (24% vs. 36% for the deceased).

Conclusion: Over a third of AAs used hospice care before they died, with LOHS slightly increasing from 2016 to 2020. Utilization of hospice care varied by gender and survival status, but most remarkably across states. Further research should examine the timing, triggering events, and other multi-level factors influencing hospice use.

C47 Resident Presentation

Proactive Care Home Rounds to Detect Early Deterioration and Reduce Hospital Admissions: An Observational Study in the UK

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Background: An ageing population continues to increase pressure on acute and out-of-hours (OOH) services. Evidence from the Evercare programme shows that care home reviews improve quality of care without significant reduction in morbidity or emergency admissions[1]. To identify local drivers of emergency and OOH demand, we audited care home callouts to assess where General Practice input could intervene, aiming to move away from episodic reviews. Although the NHS Enhanced Health in Care Homes framework recommends weekly GP rounds[2], there is no standardised approach. Reviews are often triggered by staff or family, with little anticipatory care. We implemented baseline geriatric assessment with weekly reviews and regular liaison with care homes to detect early decline.

Methods: Across 2 care homes (118 residents, mean age 79) each patient had a baseline Comprehensive Geriatric Assessment and Clinical Frailty Scale score. Patients were categorised into red, amber and green according to admission risk, guiding proportional oversight. Care home MDTs ensured coordination with community teams. Reviews were hybrid (in-person and telemedicine), with staff trained to recognise red-flag changes and send photos or updates for remote decisions where appropriate. Anticipatory elements included: personalised admission avoidance plans, review of PEACE plans and DNACPRs, and pre-emptive family discussions to set realistic expectations and preferred care pathways.

Results: 61% of weekly reviews involved 28% of residents. Following implementation, all patients were reviewed weekly. This facilitated earlier de-escalation after acute illness. Within 3 months, 53 previously unreported issues were identified, including new frailty (n=12), changes in advanced care plans (n=11), postural hypotension (n=8), and skin lesions (n=3). 57% reflected avoidable deterioration.

Conclusion: Regular reviews can detect early decline and reduce crisis admissions. Lack of explicit commissioning contributes to considerable variation in proactive care across primary care in the UK. Establishing a standard would promote improved outcomes.

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C48 Resident Presentation

Evaluation of Osteoporosis Treatment Selection Among Older Adults in Primary Care

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Background: While antiresorptive agents remain the first-line treatment for most patients with osteoporosis, anabolic therapies (parathyroid hormone receptor agonists and anti-sclerostin antibody) have emerged as an option for patients at a very high risk of fracture.¹ Despite this, anabolic agents are underutilized in practice, and their cost, subcutaneous administration, and lack of prescriber familiarity have been cited as potential barriers to use.^{2,3} The aim of this project was to identify patient candidates for anabolic therapy within a geriatric primary care clinic.

Methods: This project was a retrospective chart review of patients ≥ 65 years of age with a diagnosis of osteoporosis at two outpatient geriatric primary care clinics (GCCs). Of this cohort, two sub-groups were examined: 1) patients currently prescribed an oral bisphosphonate 2) patients co-managed by a pharmacist for denosumab or zoledronic acid therapy. A pharmacist embedded in the clinic reviewed each patient's chart to determine if they met anabolic

treatment criteria per the 2020 Endocrine Society recommendations at the time of treatment initiation and at the time of chart review.¹ The primary outcome was the number of patients who met criteria for anabolic agent treatment for osteoporosis at the time of chart review. Descriptive statistics were used to evaluate data.

Results: Seventy-nine patients ≥ 65 years of age across both clinics were included. It is anticipated that a standardized drug therapy protocol including consideration of anabolic agents may increase their utilization within primary care.

Conclusions: Pharmacists can assist providers in the appropriate therapy selection for osteoporosis treatment in older adults.

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C49 Resident Presentation

Pneumococcal Vaccine Uptake and Shared Decision-Making Among Immunocompromised Veterans Aged 65 and Older at VA Sierra Nevada Health Care System (VASNHCS)

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Background: Recent updates to pneumococcal vaccination guidelines consistent with the Advisory Committee on Immunization Practices (ACIP), recommend a single dose of the PCV20 or PCV21 for immunocompromised adults aged 65+, who previously received PCV13 at any age and PPSV23 at age 65+, utilizing shared clinical decision-making. Veterans achieved pneumococcal vaccination rates up to 71.1% for ages 65–79 versus 59.8% in nonveterans (2016–2018 National Health Interview Survey data), yet coverage remains below the Healthy People 2020 target of 90%, indicating a persistent gap. Real-world data on PCV20 or PCV21 uptake and shared decision-making among immunocompromised Veterans aged 65+ who meet updated criteria remain limited, underscoring the need to align practice with current guidelines and strengthen pneumococcal disease prevention.

Methods: This quality improvement project employed structured query language to extract data from the Department of Veterans Affairs corporate data warehouse on Veterans aged 65 years and older who fulfilled ACIP's definition of immunocompromised previously vaccinated with PPSV23. Eligible patients were analyzed from September 8, 2023, to September 8, 2025, to assess shared decision-making and pneumococcal vaccination per CDC guidance. Patient-specific factors, including demographic, clinical, and provider factors, were systematically evaluated. Additionally, a validated vaccination questionnaire was distributed to providers to capture their perspectives on pneumococcal vaccines and shared decision-making practices.

Results: Of 420 PPSV23 experienced immunocompromised Veterans aged 65+, 27 received PCV20, primarily white (82%), male (96%), with a mean age of 79. Uptake was greatest among those undergoing oncologic therapy, immunotherapy, HIV treatment, or chemotherapy. PCV20 was most often ordered by PACT providers, highlighting real-world vaccination patterns and opportunities for targeted interventions.

Conclusion: PCV20 uptake among PPSV23 experienced immunocompromised Veterans aged 65+ at VASNHCS remain low. Efforts to promote vaccination and strengthen shared decision-making and guideline adoption for those meeting eligibility criteria may further enhance pneumococcal disease prevention in this high-risk population.

C50 Resident Presentation

Pharmacist-Driven Hypertension Management in Geriatric Primary Care

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Background: Hypertension is highly prevalent among adults 60 years and older, yet fewer than half achieve blood pressure (BP) below 140/90 mm Hg. The 2025 AHA hypertension guidelines emphasize individualized BP targets for older adults, particularly those with frailty or multiple comorbidities. Older adults face barriers to BP control, including polypharmacy, altered pharmacokinetics, orthostatic symptoms, and fall risk. Pharmacists may improve BP control through expertise in regimen complexity, identification of nonprescription products that worsen BP control, such as NSAIDs, decongestants, and antacids.

Methods: This prospective quality improvement project was conducted at a geriatric primary care clinic. Adults aged 60 to 85 years with hypertension and at least two prior BP readings above 140/90 mm Hg were included. Exclusion criteria were hypertensive emergencies, secondary hypertension, end stage renal disease, and severe aortic stenosis. Pharmacist interventions included standardized BP measurement, initiation or titration of antihypertensive medications, detailed review of OTC products, adherence and lifestyle counseling, review of home BP monitoring, and orthostatic BP screening. Data were obtained from the EHR or patient reported sources. Analyses compared baseline and most recent BP and characterized pharmacist interventions and safety outcomes.

Results: Adults aged 60 to 85 years were included. The cohort was 88% female and 12% male. Seventy five percent were White, and 25% were Asian. Thirty eight percent identified as Hispanic ethnicity. Mean baseline BP was 148/78 mm Hg, and 38% achieved BP below 140/90 mm Hg at follow up. Across 18 pharmacist encounters, interventions included nine titrations, one medication initiation, six adherence focused counseling sessions, and comprehensive review of OTC medications, with no deprescribing events. No orthostatic hypotension, injurious falls, acute kidney injury, hyperkalemia, or hypotension related events were documented.

Conclusions: Preliminary findings suggest that pharmacist-led hypertension management in geriatric primary care may improve BP control while maintaining a strong safety profile. Early reductions in systolic and diastolic BP and frequent adherence-focused interventions highlight the value of pharmacists in addressing barriers unique to older adults. Ongoing follow-up will further determine the program's clinical impact and potential scalability.

C51 Resident Presentation

Utility of the SARC-F Questionnaire for Identifying Sarcopenia in Community Dwelling Older Adults.

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Background. Sarcopenia contributes to functional decline, hospitalization, and loss of independence in older adults, making early outpatient detection essential. **Methods.** This retrospective study evaluated the feasibility of integrating the SARC-F questionnaire into routine visits in an academic geriatric clinic. **Results.** Community-dwelling adults aged ≥ 63 years were screened October to December 2025. Among 20 adults screened (mean age 75; diverse racial/ethnic backgrounds), SARC-F scores ranged from 0–8, with 70% screening positive (≥ 4). High-risk individuals commonly had contributing conditions such as vitamin D deficiency (80%), Parkinson's disease, chronic pulmonary disease, or malignancy. Screening prompted further assessment including gait speed, grip strength, falls-risk evaluation, and targeted laboratory testing (CBC, CMP, TSH, vitamin D, B12, testosterone when indicated, and inflammatory markers). Most patients (75%) were referred to physical or occupational therapy,

although 25% declined. Those already engaged in exercise programs received counseling on resistance training and nutrition. **Conclusions.** This project demonstrated that SARC-F screening is feasible, supports early sarcopenia identification, and facilitates timely PT/OT involvement. Universal OT evaluation improved functional assessment, and the high prevalence of vitamin D deficiency highlights the value of paired laboratory screening. This model is scalable to other outpatient settings aiming to enhance sarcopenia detection and comprehensive geriatric care.

C52 Resident Presentation

Enhancing the Initiation Rates of Continuous Glucose Monitoring Technology in Patients Admitted to a Community Living Center

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Background: Managing diabetes in older adults in long-term care settings such as the Community Living Centers (CLCs) is challenging due to comorbidities, polypharmacy, and heightened risks of hypo/hyperglycemia. Continuous glucose monitor (CGM) use can improve glycemic control and medication safety, but its use at the Minneapolis Veterans Affairs Health Care System (MVAHCS) CLC is limited by workflow barriers and lack of standardized CGM initiation protocols. This quality improvement project aimed to establish a CGM initiation protocol and provide interdisciplinary training to increase CGM utilization in hospitalized older adults.

Methods: This single-center prospective quality improvement project was conducted at the MVAHCS CLC over 3 months. A CGM initiation protocol and note templates were established. Targeted education on the CGM protocol and technology was provided to physicians, pharmacists, and nurses. Surveys were administered pre/post education to assess provider comfort with CGMs. Eligible patients included those admitted between 5/2/25-8/2/25 who received scheduled insulin. Data collection occurred via automated electronic health record (EHR) extraction and manual chart review. The primary outcome was the number of patients initiated on a CGM 3 months after the educational sessions. Secondary outcomes included: staff comfort levels, medication changes, CGM discharge outcomes, and number of CGMs initiated at 6 months. Descriptive statistics were used to summarize results.

Results: At 3 months, 4 patients were initiated on a CGM, and an additional 5 patients were initiated at 6 months post-education. Insulin dose changes were made in response to CGM results at least once for each patient and all were discharged with the CGM. There was a greater proportion of survey responses in the higher comfort levels in the post-survey compared to the pre-survey for all staff groups. The survey revealed the least comfort with applying a CGM with requests from nurses for hands-on practice.

Conclusions: Initiation of CGMs for patients in the CLC is feasible using a standardized protocol and targeted education. Ongoing areas for improvement include incorporating educational hands-on experience, tracking workload longitudinally, and optimizing protocol language and patient education.

C53 Resident Presentation

Centering the Aging Patient: A Family Friendly Medicine Clinic's Journey Towards Age-Friendly Care

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As the U.S. population continues to age - with nearly 17% of Americans now 65 years or older per the 2020 Census - the need for tailored, high-quality care for older adults is increasingly urgent. In response, our clinic is working to enhance care for this population by pursuing the IHI Age-Friendly Health System designation,

which incorporates the 4Ms framework: What Matters, Medication, Mentation, and Mobility. This project aims to identify areas for improvement in primary care for older adults and guide our transformation into an Age-Friendly Health System. By implementing the 4Ms, we seek to improve the quality, consistency, and person-centered nature of geriatric care. The overarching goal is to evaluate the process of becoming age-friendly and assess its impact on patient outcomes. In 2024, the Methodist Charlton Family Practice care team collaborated with experienced clinicians to complete the application for Level 1 Age-Friendly designation. The committee evaluated the current practice against the minimum criteria for each of the 4Ms, including standardized encounter questions, evaluation frequency, documentation needs, action steps, and care team responsibilities. When criteria were not met, the team identified strategies for improvement and implemented changes over a one-month period. The final application confirmed that our clinic met the minimum standards for all components of the 4Ms framework. A major factor in meeting these requirements was the structured use of the Medicare Annual Wellness Visit (AWV), which provided a consistent approach to evaluating each domain. The health risk assessment and advance care planning supported conversations around What Matters. Medication reconciliation addressed the Medication domain, emphasizing review of potentially inappropriate medications. Cognitive assessment tools met Mentation criteria, while functional status evaluations—including fall risk screening and the Timed Up & Go test—addressed Mobility. Using the AWV template enabled us to systematically integrate the 4Ms and achieve Level 1 Age-Friendly designation. Moving forward, we will evaluate how applying this framework during routine visits influences patient outcomes by tracking the proportion of older adults receiving 4M care. These data will guide our efforts toward achieving Level 2 recognition.

C54 Resident Presentation

Veteran and Care Partner Experiences with Patient Priorities Care (PPC) Focused Geriatric Consultation Clinic

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Background: Identifying what matters most to older adults is important for fostering meaningful conversations and addressing unmet needs. Patient Priorities Care (PPC) is a 'what matters' framework that guides Age-Friendly assessments and recommendations based on patient health goals and values. Patient values, healthcare preferences, and bothersome treatments were explored during a phone call prior to the appointment. During the visit, the physician used PPC to determine a specific goal guiding Age-Friendly assessments and recommendations. Few studies have examined Veteran and Care Partner experience and acceptability with PPC, which may help inform comfort with 'matters most' conversations and this consultation model.

Methods: Patients who were seen in the consultation clinic were invited for interviews; Care Partners that had attended PPC visits were also invited. Semi-structured interviews focused on understanding the Veteran and Care Partner experience with PPC, impact on health care decisions, and perception of quality of care and access were conducted January-June, 2025. A matrix analysis focused on a priori themes of the interviews. Emergent themes were also identified in the matrix analysis.

Results: Twenty-three total interviews with Veterans and/or Care Partners were completed within a mean of 23 days after PPC visit. Phone calls prior to the initial visit prepared patients for values-based discussions. Participants were comfortable sharing what matters with physicians and perceived that the visit helped ensure healthcare decisions aligned with their values. Care Partners felt the visit clarified their role in the care of Veterans and fostered support. Participants valued the time allotted for appointments and preferred in person appointments.

Conclusions: Our qualitative analysis suggests framing geriatric consultation by the PPC approach is valued by Veterans and Care Partners. Best practices include a values priming call, including Care Partners, allowing ample time for appointments, and in person visits. These findings may help improve delivery of services to align health-care with what matters most to Veterans.

C55 Student Presentation

Seizure Due to Abrupt Gabapentin Cessation

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Background:

Polypharmacy and potentially inappropriate medications are common in older adults. The prolonged or improper use of multiple medications has been associated with an increased risk of adverse events. Gabapentin is widely prescribed for neuropathic pain, restless leg syndrome, alcohol withdrawal, hiccups, and other conditions. Its use more than doubled from 2010 to 2024, making it the fifth most prescribed medication in the US. While its use has increased, its withdrawal symptoms are underrecognized. We present the case of a 69-year-old male who experienced a seizure following discontinuation of gabapentin during hospitalization.

Case:

A 69-year-old male with chronic neuropathic pain and quadriplegia initially presented for lethargy in the setting of hypoglycemia, hyponatremia, bilateral pleural effusions, and UTI. Home pain regimen included gabapentin 900mg four times a day, baclofen, oxycodone, and ibuprofen. The patient's lethargy initially improved with treatment for UTI, hypoglycemia, and hyponatremia. Gabapentin was held, and other pain meds were reduced due to lethargy. On the third day, the patient had sudden irregular movements of the head and left shoulder, concerning for a seizure. vEEG, MRI brain, and other labs were unremarkable. Gabapentin was resumed at 600mg TID. No further episodes of seizure-like activity observed.

Discussion:

This case highlights the critical importance of polypharmacy management, appropriate medication review and deprescribing, and recognition of gabapentin withdrawal symptoms in older adults. While deprescribing is generally encouraged, it is crucial to note that certain medications require slow tapering to avoid withdrawal symptoms.

Gabapentin withdrawal symptoms may include diaphoresis, tachycardia, irritability, anxiety, delirium, and, in severe cases, seizures. Because gabapentin acts as a central nervous system depressant by modulating GABA-related neurotransmission, abrupt discontinuation can lead to rebound neuronal hyperexcitability, leading to seizures.

Conclusion:

Gabapentin use has increased rapidly in recent years, yet its withdrawal symptoms remain underrecognized. Although deprescribing is recommended when appropriate, gabapentin must be tapered slowly to prevent withdrawal symptoms.

C56 Student Presentation

Stopping Clots to Stop Bleeding: Warfarin-Responsive GAVE in Scleroderma

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Background:

Gastric antral vascular ectasia (GAVE) is a microvascular manifestation of systemic sclerosis and may precede cutaneous signs, delaying diagnosis. Although up to 65% of GAVE is cirrhosis-related, up to 30% of non-cirrhotic cases are associated with scleroderma. We describe a 16-year case in which transfusion-dependent GAVE, chronically elevated D-dimer, central retinal vein occlusion (CRVO), and

late-onset limited cutaneous systemic sclerosis (lcSSc) were retrospectively unified. A paradoxical remission of GAVE bleeding occurred only during warfarin therapy.

Methods:

This retrospective single-patient review (2009–2025) was conducted in a geriatric practice. Data were drawn from serial evaluations by geriatrics, gastroenterology, cardiology, rheumatology, and ophthalmology; endoscopy reports; CT thorax, US abdomen, PFT testing, echocardiography, autoimmune serologies, and longitudinal laboratory trends including hemoglobin, ferritin, iron indices, and D-dimer.

Results:

68 y.o man started to be seen in 2009, due to AFIB with RVR and recurrent melena and transfusion-dependent anemia due to GAVE requiring frequent argon plasma coagulation. During a 10-month course on warfarin for a left atrial appendage thrombus, GAVE bleeding nearly resolved, and no endoscopic interventions were needed. After anticoagulation was stopped following SVT ablation, GAVE again worsened. Over 16 years, the patient developed mild sclerodactyly prompting ANA testing that revealed high-titer anti-centromere antibodies (1:1280), along with CRVO treated with intravitreal bevacizumab, mildly reduced DLCO, and CT-confirmed mild ILD. Telangiectasias were absent on skin and mucosa, but visceral telangiectasia (GAVE) persisted. D-dimer was chronically elevated off warfarin (0.86–1.18 µg/mL) and decreased while anticoagulated (0.20–0.40 µg/mL). Echocardiography showed no pulmonary hypertension. Azathioprine was recently initiated.

Conclusions:

This case shows that limited scleroderma may first be present through isolated visceral micro-vasculopathy before skin findings emerge. The unexpected remission of GAVE-related bleeding during anticoagulation supports a micro-thrombotic mechanism in lcSSc and suggests that targeted antithrombotic strategies may have therapeutic relevance. Long-term continuity of care was essential in recognizing this delayed autoimmune diagnosis in an older adult, although clinicians may consider early autoimmune evaluation on initial GAVE detection.

C57 Student Presentation

The Silent Signals: Lessons from an Atypical Presentation of Renal Cell Carcinoma

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Background:

Renal cell carcinoma (RCC) is often incidentally discovered on imaging. The classic symptoms include hematuria, flank pain, and an abdominal mass, but over 50% of cases present atypically. This case highlights the diagnostic uncertainty for a patient with dyspnea.

Case Summary:

A 74-year-old woman with hypertension and functional neurologic disorder (FND) presented with months of dyspnea on exertion and dizziness. She reported shortness of breath, unsteadiness, and palpitations, expressing significant anxiety about her symptoms. Although her physical exam was unremarkable, she became tearful describing how her health changes caused debilitating depression, making her feel she had to “hide” around others.

The initial differential diagnosis included cardiac and pulmonary pathology, anemia, and panic disorder. Given her benign exam, cardiopulmonary concerns seemed less likely. Workup included a normal chest x-ray, unremarkable echocardiogram, ZioPatch with no arrhythmia, and hemoglobin of 10.7. She was referred to social work for therapy.

Two months later, she returned with worsening dyspnea, difficulty taking deep breaths, nausea, and reduced appetite. Her anxiety worsened with her symptoms. The differential was expanded to consider

medication side effects, GERD, and vocal cord dysfunction. Her anti-hypertensive was switched from lisinopril to losartan, and she started citalopram. A PPI was discussed but deferred, and she was referred for vocal cord evaluation.

She later sought care at an outside hospital for worsening symptoms. CT imaging revealed abnormal liver lesions; follow-up imaging showed cystic lesions and lymphadenopathy, raising suspicion for malignancy. An expedited workup revealed a left renal mass, and an IR-guided biopsy confirmed metastatic renal cell carcinoma.

Discussion:

With the cancer diagnosis, potential contributors to her dyspnea included anemia from malignancy, pain from liver capsule stretching, and mass effect from hepatic lesions. No single diagnosis fully explained her respiratory symptoms, highlighting the complexity of her presentation.

This case underscores the importance of recognizing atypical RCC presentations. The patient's identity as a Black woman with known FND may have influenced the interpretation of her symptoms, potentially prolonging the diagnostic process. Healthcare professionals must be aware of systemic racism and mental health stigma, which can shape clinical reasoning and treatment.

C58 Student Presentation

Qualitative Insights from Geriatric Rehabilitation Staff

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Background: With a rapidly aging population in the United States (Butler, 2024), demand for geriatric inpatient rehabilitation and long-term care facilities is intensifying (Tijssen, Derksen, Achterberg, & Buijck, 2023). This trend poses significant challenges for both the healthcare system and the broader social fabric of the US (Butler, 2024). This qualitative pilot study aimed to explore staff and patient interactions at an inpatient rehabilitation facility.

Methods: Observations and semi-structured interviews were conducted at an inpatient rehabilitation facility in the southeastern United States. Permission was granted by the facility administrator. The goal of the observations was two-fold, to see staff interacting with patients and to decide on potential participants for the semi-structured interviews. Once the participants were identified and asked to participate, the interviews were scheduled at the convenience of the participants via phone. The audio of the interviews was recorded using the verbatim transcription function in Zoom.

Results:

Findings from direct observations showed that staff were more likely to interact with other staff members, often leading to patients sitting alone with little to no interaction. The rehabilitation center aims to create a supportive environment to achieve patient satisfaction and positive outcomes. There is a notable incongruence between what was shared with me during interviews and what I actually witnessed.

Conclusions:

Most of the staff interacted well with each other. However, I did not witness many positive interactions among the staff and patients. From my observations (albeit short in time), it appears as if there could be a generational issue that may interfere with younger staff knowing how to talk with the geriatric patients. Several times I observed jovial banter between staff members but did not see these same casual interactions with the patients. There was a separateness that permeated through the entire facility. While the overall goal in a rehabilitation facility is patient satisfaction and positive outcomes, the vulnerability of the patients in their care must be handled with dignity and interactions must be guided by high expectations for excellent care. Sadly, many situations do not live up to these ideals.

C59 Student Presentation

Evaluating Discordant Glycemic Markers in a Diabetic patient

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Background:

Hemoglobin A1c (HbA1c) is a widely used marker for monitoring and assessing long-term glycemic control in patients with diabetes or those at risk (1). However, certain clinical conditions, such as hemoglobin variants, blood disorders, or renal dysfunction, may lead to discordance between HbA1c levels and blood glucose readings (2). In such cases, other alternative markers, such as fructosamine levels, can provide additional context.

Methods:

This case describes a 71-year-old, East Asian, male patient with a 10-year history of known type 2 diabetes who was noted to have discordant blood glucose values and HbA1c. His blood glucose values ranged from 150-280 mg/dL for months, whereas HbA1c values were consistently lower at 5.8% (5-6%). Ultimately, fructosamine level was found to be 419, and the calculated HbA1c was 8.7% which is discrepant from the measured HbA1c of 5.8%.

Results:

Laboratory studies showed a hemoglobin value of 13.1 g/dL, eGFR of 92 mL/min/1.73 m², and a normal hemoglobin electrophoresis result, which ruled out conditions such as hemoglobinopathies, anemia, and significant renal dysfunction. The medications have been modified to metformin 1000 mg BID, repaglinide 1 mg BID AC, and empagliflozin 10 mg daily. After 3 months, his subsequent home blood glucose levels improved to the range of 120s-140s, and repeat HbA1c was 4.5% and his fructosamine was 312, with a calculated HbA1c is 6.9% (at goal) but still discordant.

Conclusion:

Discordance between HbA1c and glucose measurements can happen for many reasons, including hemoglobin variants, undetected kidney disease, and other reasons. In this patient, the etiology remains unclear. For future circumstances, clinicians must verify the validity of HbA1c values when laboratory results do not agree with self-monitored blood glucose readings.

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C60 Student Presentation

A Silent Presentation of Transient Hepatocellular Injury in Acute Cholecystitis

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Background:

Cholecystitis is a condition in which the gallbladder becomes inflamed and is typically characterized by symptoms such as right upper quadrant pain, fever, and a positive Murphy's sign. However, a subset of patients can be asymptomatic without classic features. More specifically, elevated liver enzymes are observed in patients with acute cholecystitis without coexisting choledocholithiasis. Here we describe a patient who was asymptomatic and had elevated liver enzymes on routine testing, with imaging evidence of cholecystitis.

Methods:

This case describes a 78-year-old female patient who was noted to have abnormal liver function tests on routine lab testing. She was asymptomatic and denied any complaints of abdominal pain, fever, nausea, or vomiting. CT scan showed a distended gall bladder with stones and pericholecystic fluid concerning for acute cholecystitis, with a normal common bile duct with no stones in the CBD. She was sent to the ED for further evaluation.

Results:

Laboratory findings demonstrated persistent elevation of ALT and AST, peaked at 786 U/L and 555 U/L, respectively, and ALP up to 312 U/L with normal bilirubin levels. MRI confirmed the presence of gallstones, gallbladder distension, and cholelithiasis with normal CBD. Despite her being asymptomatic with elevated LFTs, she underwent a laparoscopic cholecystectomy with no post-operative complications. Literature review suggested that elevated liver enzymes are directly due to the oxidative stress phenomenon secondary to cholecystitis, and it is observed that it resolved after the cholecystectomy procedure.

Conclusions:

This case highlights an atypical presentation of cholecystitis, which can rarely be presented by abnormal LFTs without the classic biliary symptoms. For future cases, physicians should understand the importance of monitoring unexplained elevations of liver enzymes even in the absence of symptoms. Early identification and intervention can be crucial in helping prevent severe clinical complications.

C61 Student Presentation

Presented with fractures, left without an appendix; a case of concurrent traumatic injuries and appendicitis

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Introduction:

Trauma due to falls is associated with significantly higher morbidity and mortality in geriatric patients when compared to younger adults. In the emergency department, older adults presenting after a fall require a thorough evaluation for traumatic injuries, contributing factors and future fall risk. Acute appendicitis is an uncommon diagnosis in geriatric patients, as the peak incidence occurs in young adulthood. We present a case of acute appendicitis in a geriatric patient who was admitted for traumatic fractures after a fall.

Case:

73-year-old male with past medical history of coronary artery disease presented after falling from a ladder, which resulted in rib, sacral and lumbar fractures. During the evaluation, he also reported three days of significant and persistent right lower quadrant pain, for which he had not sought medical care. He denied nausea, vomiting and fevers. Trauma workup included a CT chest, abdomen and pelvis, which revealed left-sided rib fractures (9th-12th), displaced fractures of L1-L3 and L5, left S1 sacral fracture, and displaced fractures of the left acetabulum and inferior pubic ramus. Incidentally, his CT also showed acute appendicitis without perforation. His CBC showed WBC $14.0 \times 10^3/\mu\text{L}$ with a left shift. On physical exam, his abdomen was soft, non-distended and tender over McBurney's point without guarding or peritoneal signs. He underwent laparoscopic appendectomy the next day without complication. The orthopedic team recommended nonoperative management of his fractures. He was discharged home a few days later with home physical therapy and orthopedic follow-up.

Discussion:

Falls in older adults are most often attributed to gait and balance disorders, polypharmacy, and environmental hazards. This case illustrates how concurrent acute illness can also contribute to traumatic events. This patient's abdominal pain and unrecognized acute appendicitis likely contributed to his fall. This case reminds us that the most revealing diagnosis during a fall evaluation may be less common and demonstrates the importance of history taking and incidental findings.

C62 Student Presentation

Severe Hypercalcemia Caused by Vitamin D Toxicity.

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Background: Hypercalcemia is a potentially serious electrolyte abnormality associated with neurological, renal, skeletal, and cardiovascular complications. Common etiologies include hyperparathyroidism, malignancy, medications, and vitamin D intoxication. Vitamin D toxicity is rare and typically results from excessive supplementation or endogenous overproduction, leading to elevated 25-hydroxyvitamin D concentrations and increased intestinal calcium absorption. Hypercalcemia of malignancy often occurs in advanced cancer and may be mediated by parathyroid hormone-related peptide (PTHrP), cytokine-induced osteolysis, or tumor-driven vitamin D activation.

Methods: Case Report.

Discussion: We present a 67-year-old man with recurrent falls, a right intertrochanteric fracture, and symptoms consistent with chronic hypercalcemia, including constipation, weakness, weight loss, and nephrolithiasis. Laboratory evaluation demonstrated severe hypercalcemia (14.1 mg/dL), suppressed PTH, markedly elevated vitamin D levels (>200 ng/mL), and increased PTHrP (4.8). These findings suggested vitamin D toxicity as the primary etiology, with possible PTHrP-mediated hypercalcemia. Imaging excluded multiple myeloma and solid organ malignancy, yet the elevated PTHrP warrants continued evaluation for hematologic or benign sources. Treatment included volume resuscitation and zoledronic acid, resulting in progressive normalization of calcium. This case illustrates the diagnostic complexity of hypercalcemia when multiple etiologies coexist. Similar reports describe concurrent vitamin D intoxication and PTHrP elevation, though malignancy was typically identified.

Conclusion: Severe hypercalcemia may result from overlapping mechanisms. Detailed medication history and comprehensive workup are essential, particularly when supplementation is involved. Clinicians should recognize vitamin D toxicity as a reversible cause and maintain vigilance for occult malignancy or benign PTHrP-producing processes. Early identification and targeted management can prevent long-term renal and skeletal complications.

C63 Student Presentation

Patient Education and Continuity of Care - Vital Aspects of Caring for Patients Taking Exogenous Thyroid Hormone: A Case Study

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Background: Patients with thyroid gland dysfunction or history of thyroidectomy are prescribed Levothyroxine as a first line therapy for hypothyroidism. This medication is self-administered and, as such, patients are expected to understand the risks, side effects, and dosing associated with this medication. Misuse or abuse of levothyroxine can be dangerous and can lead to hospitalization and mortality. This case highlights factors which may contribute to levothyroxine misuse in older adults with limited medical literacy.

Methods: Case Study

Case: Ms. D, an 82-year-old Spanish-speaking female with a history of hypothyroidism, heart palpitations, hypertension, hyperlipidemia, and depression. She presented to the emergency department with a two-month history of falls, presyncope, and palpitations. Evaluation revealed hyperthyroidism secondary to exogenous levothyroxine, obtained from a friend, which resulted in atrial fibrillation

and presyncope. Her endocrinologist had recently retired, and although she recalled being told to stop taking the levothyroxine, she decided to take her friend's medication instead. In conversations with Ms. D and her family, it became clear that she had not received adequate education on the purpose of the medication, dosing, or side

effects, and had no continuity of follow up with a prescribing physician. This was further complicated by the language barrier in conjunction with early memory changes affecting her ability to self-manage.

Conclusions: Iatrogenic hyperthyroidism is an underrecognized contribution to geriatric syndromes such as falls and syncope, as seen in this case. As older adults frequently must navigate complex medication regimens, consistent follow-up and accessible patient education is vital. Loss of a trusted provider, language barriers, cognitive decline, and low healthcare literacy can predispose older patients to dangerous medication misuse. This case underscores how even common and generally safe medications can become harmful, emphasizing the importance of improving patient education in the outpatient setting.

C64 Student Presentation

Iodine-induced Thyrotoxicosis: The Importance of Patient Education on Supplement Usage

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According to the CDC, the use of supplements has increased in all age groups since 2007 with the highest rate being 80.2 % among women aged 60 years and older in 2018. Physicians need to become actively engaged in the monitoring and education of over-the-counter supplement usage as these products increase in popularity among patients. This case demonstrates a rare instance of iodine-induced thyrotoxicosis in the context of Lugol's iodine solution following self-treatment of hypothyroidism. She had extensive history of supplement use including over 20 products, one being Lugol's Iodine 270 solution. The patient presented with classic hyperthyroid symptoms, including headache, shortness of breath, hypertension, and atrial fibrillation. Thyroid function tests revealed markedly elevated free T4 (3.66 ng/dL) and suppressed TSH (<0.015 uIU/mL). A diagnosis of iodine-induced thyrotoxicosis was made. She was started on methimazole and propranolol with subsequent improvement of symptoms and normalization of thyroid function.

C65 Student Presentation

Elevated hemoglobin in a 76 year-old female: This time you can blame your parents

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Hemochromatosis is a hereditary disorder of iron regulation which leads to iron accumulation in organ tissues with organ dysfunction when untreated. The symptoms of the disorder including fatigue, joint pain, abdominal pain, and weakness can be confused with other conditions leading to misdiagnosis in early stages.

A 76 year-old female with past medical history of IBS, osteoporosis, and hyperlipidemia is seen in primary care clinic for new onset generalized fatigue. Review of systems is negative for fevers, chills, night sweats, weight change, exercise intolerance, snoring, apneic episodes, depressed mood, cold intolerance, hair/skin changes, or change in bowel habits. Physical exam is unremarkable, and she is up to date on colon cancer screening. Laboratory evaluation is remarkable for elevated hemoglobin (16.5 g/dL), elevated iron (230 mcg/dL), and significantly elevated ferritin (513 ng/mL). Erythropoietin is within normal range. Patient is referred to Hematology due to concern for iron overload and found to be homozygous for the C282Y variant in the HFE gene and diagnosed with hereditary hemochromatosis. Further testing will include abdominal MRI for quantification of liver iron deposition before a treatment plan is determined.

When evaluating a geriatric patient with the chief concern of fatigue, initial workup should rule out common differential diagnoses such as iron deficiency anemia, endocrinopathy, sleep disorder, cardiopulmonary disease, or psychiatric disorder. While uncommon,

this case demonstrates elevated hemoglobin and significantly elevated ferritin should expand the list of potential differential diagnoses to include hereditary hemochromatosis. Additionally, this case illustrates that even though most genetic disorders present earlier in life, this is not true for hemochromatosis. Sex-related differences in iron metabolism explain the expected age of patient presentation with hemochromatosis. Premenopausal women lose iron through menstruation and pregnancy, delaying iron accumulation and symptom onset until post menopause. While not an everyday diagnosis to make in primary clinic, this case presents an excellent reminder to widen the differential to incorporate additional diagnoses specific to patient age and sex when unexpected laboratory results present themselves.

C66 Student Presentation

Severe Cutaneous Adverse Reaction in an Older Adult: Stevens-Johnson Syndrome after UTI Therapy

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Background

Stevens-Johnson Syndrome (SJS) is a rare, potentially life-threatening mucocutaneous reaction characterized by blistering and widespread epidermal detachment. To the author's knowledge, fewer than 5 case reports have documented SJS in the geriatric population. Long-term side effects have been documented in multiple organ systems, with ocular sequelae being the most debilitating. Here we describe a case of SJS in a 76-year-old woman who was switched to Bactrim for 1 day to complete an antibiotic course for urinary tract infection (UTI). She developed multiple blistering skin lesions, which did heal, but did go on to develop complications of SJS including significant ocular manifestations which negatively impacted her function and ultimately led to her decline.

Case

A 76-year-old woman presented with an erythematous, blanchable rash extending over the left thigh, left groin, left shoulder, and right medial posterior calf. She was being treated with 4-days of Macrobid for a UTI and switched to Bactrim at her nursing facility for unclear reasons to complete the 5-day antibiotic course. Within 24 hours, she developed blistering, pruritic lesions on her extremities that progressed to involve her trunk. The largest lesions measured 5 cm in diameter and contained overlying serous fluid.

Clinical Evaluation and Management

Bactrim was discontinued, and triamcinolone cream was applied twice daily. The lesions healed but over the following 10 months, the patient experienced a multifactorial decline in both clinical and functional status. During this period, she developed ocular impairment, raising concern for a possible SJS-related complication. Ultimately, the patient was moved to a different assisted living facility for more intensive rehabilitation and died 2 months later.

Conclusion

This case report describes a case of SJS in an older adult and illustrates that ocular decline can occur following SJS, although it remains unclear whether this patient's SJS contributed to the ocular deterioration or whether the ocular decline represented an isolated event. While there is no specific treatment for SJS, it can be managed by stopping the offending agent, initiating supportive care, and close follow up with specialists, such as ophthalmology, to mitigate the risk of long-term side effects.

C67 Student Presentation

A Case of Cannabis-Induced Hyperkalemia

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Since the deregulation of Cannabis, there has been an increase in Cannabis use by older adults for various medicinal purposes. Although there is significant research in the use of Cannabis for a variety of medical conditions, older adults are routinely underrepresented

in clinical trials. As a substance, Cannabis impacts multiple organ systems, is metabolized by cytochrome P450 isoenzymes, is known to have multiple drug-drug interactions, and causes various adverse drug reactions. There are very few guidelines provided by the medical community on the use of Cannabis in older adults and what safety parameters should be monitored. The Beer's Criteria, for example, has not addressed the use of Cannabis in older adults either as safe or inappropriate.

We present a case of a 63 yo male who presents for a clinical pharmacy appointment to discuss the onset of hyperkalemia with normal kidney function. The patient was not taking any prescription medications but was taking Lipo Flavonoids as needed and 5mg CBD gummies (containing potassium as a preservative) 3-4 times per week for sleep. After stopping cannabis for 3 weeks his potassium returned to normal. The patient was encouraged to not use CBD. The patient was advised to try melatonin supplementation for sleep as a safer alternative to cannabis or other sleep aids which can cause cognitive impairment.

This is a case presenting a possibility of Cannabis induced electrolyte imbalance.

Most commonly Cannabis results in hypokalemia. Cannabis induced hyperkalemia is uncommon and mostly seen in isolated case reports involving animals. This particular formulation of Cannabis had potassium sorbate as a preservative. The amount varies depending on the formulation and it was impossible to determine how much potassium was actually ingested. The use of CBD resulted in multiple appointments for further evaluation and additional laboratory orders resulting in increased health care costs. Providers should be routinely asking patients about their Cannabis use, just like they screen for alcohol and illicit drug use at every visit. Cannabis should be considered a drug like any other that can potentially cause unnecessary side effects and adverse events.

C68 Student Presentation Aripiprazole-Induced Parkinsonism Causing a Prescribing Cascade in an Older Adult

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Introduction:

Polypharmacy affects ~40% of older adults and increases adverse drug events and hospitalization risk (1,2). Age-related pharmacologic changes heighten toxicity risk (3). Aripiprazole, used for late-life depression, may cause parkinsonism misdiagnosed as Parkinson disease, prompting a prescribing cascade (4,5).

Case:

A 70-year-old man with hypertension, hyperlipidemia, chronic pain, depression, anxiety, and restless leg syndrome (RLS) was referred for cognitive concerns, including brain fog and short-term memory impairment, as well as for medication reduction. His psychoactive regimen consisted of clonazepam, doxylamine, fluoxetine, gabapentin, methocarbamol, pramipexole, tramadol, zolpidem, carbidopa/levodopa, and melatonin upon presentation. He had taken aripiprazole for several years for depression. While on the antipsychotic, he developed upper and lower extremity tremors and voice changes. He was diagnosed with Parkinson disease and started on carbidopa/levodopa. Persistent RLS led to dose escalation of pramipexole and gabapentin; insomnia prompted doxylamine, melatonin, and increased dosages of clonazepam and zolpidem, totaling ten psychoactive medications.

Neuropsychological testing showed mild impairment, likely from medication effects. Skin biopsy for phosphorylated alpha-synuclein was negative, making Parkinson disease unlikely. A deprescribing plan discontinued methocarbamol and doxylamine, tapered zolpidem, and initiated cognitive behavioral therapy for insomnia.

Gradual discontinuation of carbidopa/levodopa, pramipexole, and benzodiazepines was planned, along with iron repletion for RLS.

Discussion:

Aripiprazole-induced parkinsonism led to misdiagnosis and a prescribing cascade. Recognizing drug-induced syndromes and structured deprescribing can reduce polypharmacy, improve cognition, and enhance safety in older adults (6,7).

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C69 Student Presentation Prosthetic Aortic Valve Infective Endocarditis with Septic Brain Emboli in an Octogenarian

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Introduction: Prosthetic valve infective endocarditis (IE) is a rare, potentially fatal disease.¹ Septic emboli occur in 22-55% of IE with up to 65% involving the central nervous system (CNS).² *Streptococcus viridans* causes 20-40% of all IE cases with a mortality rate of ≥20%, though only 11-13% of reported cases have neurologic emboli.^{3,4} This is a unique case of an octogenarian with *Streptococcus viridans* prosthetic valve endocarditis with associated septic posterior circulation brain emboli.

Case Description: An 81-year-old male with history of aortic stenosis with remote bioprosthetic valve replacement was hospitalized in Spain for confusion, ataxia, and fever. One month after his return to the United States, he presented to the local ED with similar symptoms. On physical exam, the patient had excellent dentition, a chronic systolic murmur, and right upper extremity dysmetria and ataxia. Brain MRI showed acute infarcts in bilateral occipital lobes and left cerebellum. Transesophageal echocardiogram showed a 6 x 5mm aortic valve vegetation. Blood cultures grew *Streptococcus viridans*. The patient underwent aortic valve replacement and completed a four-week course of IV ceftriaxone.

Discussion: Prosthetic valve infective endocarditis is a rare, potentially fatal disease. Among patients with *Streptococcus viridans* IE, only 11-13% have reported CNS emboli. Emboli in the posterior CNS circulation is atypical, as >90% of IE CNS emboli occur in MCA.² This case highlights an atypical presentation of prosthetic valve IE with posterior circulation septic brain emboli and the importance of considering brain emboli in older adults with delirium.

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C70 Student Presentation

Atypical Case of Refractory Burning Mouth Syndrome

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Introduction:

Burning mouth syndrome (BMS) is a condition characterized by a burning sensation in the mouth or tongue without visible signs of damage. Incidence is about 2%, 7 times more in women. Reports indicate that two-thirds of patients have spontaneous recovery within 6–7 years. Treatment is challenging and involves topical and systemic agents.

Case Presentation:

An 84-year-old female presented with BMS, which was diagnosed over 20 years ago. Her symptoms began after a denture placement, which she suspected caused an allergic reaction to dental polymer; however, this was ruled out after further investigation. She has seen over 40 specialists, including otolaryngologists, allergists, oral surgeons, dermatologists, gastroenterologists, and dentists. All workup for allergies, vitamin deficiencies, celiac disease, Sjogren's syndrome, and pernicious anemia was unremarkable. She has tried multiple therapies, including gabapentin, pregabalin, nystatin, tricyclic antidepressants, magic mouthwash, corticosteroids, and proton pump inhibitors, without any benefit. She currently uses clonazepam as needed for BMS-associated anxiety and depression. This chronic pain has caused significant weight loss, anxiety, and depression.

Discussion:

This case highlights the diagnostic and therapeutic challenges of long-standing BMS. Previous case reports have shown that medications such as ACE inhibitors and SSRIs can cause BMS, where symptoms resolve after discontinuation of the identified medication. Other cases have shown a response to clonazepam, gabapentin, and pregabalin. For our patient, none of the treatment options were successful except clonazepam for BMS-associated anxiety.

Conclusion:

This case highlights the diagnostic complexity of refractory BMS, which has persisted for two decades, despite numerous medication trials. Experiencing these chronic symptoms without any known cause or treatment can contribute to behavioral symptoms such as anxiety and depression. Furthermore, it emphasizes the need to focus on managing the multisystemic consequences of this condition.

C71 Student Presentation

Nutritional Assessment of Geriatric Trauma Patients at a Rural Trauma Center

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Background: The geriatric population (GP) is the fastest growing demographic in the US. Malnutrition is often underrecognized with estimates as high as 65% in hospitalized GP. Early, accurate nutritional assessment (Nutra-A) for malnutrition is essential. CMS/Medicare requires Nutra-A for GP and proposes financial penalty for noncompliance; however, best practices remain underexplored and nonstandardized. With trauma the 5th leading cause of death in GP, we evaluated the MiniNutritional Assessment Tool (MNA) and Braden Score to assess usefulness and concordance in the hospitalized geriatric trauma population (GTP).

Methods: Study design: prospective observational study of GTP admitted for > 48 hrs at a Level I Trauma Center. Inclusion criteria: age > 65 years, injury admission diagnosis, able to participate in MNA by patient and a POA. Demographics, BMI, and nutrition segment of the Braden Score abstracted from the EMR. Nutrition consults were ordered for BMI < 18 and MNA scores < 17.

Results: 85 (62%) GTPs met inclusion criteria. Average age: 79.4 ± 8.3. 54 (63.5%) females. Average BMI = 27.1 ± 6. 6 GTP

(7%) had a BMI < 18.5. The avg MNA score for the cohort was 22.9 ± 5.2 with scores being normal (> 23) in 47 (55.3%), at risk (17–23) in 25 (29.4%) and malnourished in 13 (15.3%). In POA surveys, average MNA score was 22.7 ± 5 with normal scores in 50 (58.8%), at risk in 23 (27.1%) and malnutrition in 12 (14.1%). POA designees were: GTP's children in 40 (47%), spouse 30 (35.3%), and extended family 12 (14.1%). The average variance between MNA given by GTP and POA was 0.26 ± 2.26 (range -12 to +6). This would have altered decision-making in 4 GTP. For nurse-obtained Braden scores (1-minimal intake, 2-reduced intake, 3 or 4 indicating at least adequate intake), the avg score = 2.8 ± 0.45 with 81% normal and 18% malnourished. Braden score matched with patient NMA score in 63.5%. 30.6% were rated better than GTP MNA and 5.9% worse. Overall, patient MNA, POA MNA and Braden score results were concordant in 70 (82.4%) of patients. 17 GTP (20%) received nutrition consults.

CONCLUSION: Our data suggests 45% of GTP are at-risk or malnourished. BMI, identified less than 50% of these. If a GTP cannot complete a Nutra-A for any cause, POA is generally reliable. The Braden score nutrition value is less accurate. Use of the NMA in GTP improves recognition and treatment for nutritional deficiency.

C72 Student Presentation

LATE Manifestations in Older Woman with Suspected Alzheimer's Disease

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Background: Limbic-Predominant Age-Related TDP-43 Encephalopathy (LATE) was first defined as a clinical dementia subtype in 2019 and results from pathologic aggregation of the TDP-43 protein. Clinically, it mimics AD with indolent onset, temporolimbic amnesia, and significant hippocampal atrophy. However, LATE is characterized by cognitive impairment in the absence of classic AD biomarkers, with LATE being increasingly identified in the workup of dementia, most commonly in patients in their 80s and 90s. With new anti-amyloid immunotherapies approved for AD and the lack of currently available LATE biomarkers, it is becoming crucial to differentiate and diagnose LATE.

Disease Presentation: We describe an 88-year-old female with a past medical history of hypertension, hyperlipidemia, type 2 diabetes, and alcohol use, who presented with complaints of increased forgetfulness over the last six years, accelerated short term memory decline in the past year, and recent episodes of impaired judgment. Her family desired evaluation for AD and Lecanemab therapy. Initial workup with brain MRI showed markedly diminished hippocampal and entorhinal cortices with diffuse cerebral volume loss. Amyloid PET scan showed negative amyloid plaque burden. The patient had an ApoE ε3/ε3 genotype. Clinical assessment revealed the patient was independent in her ADLs and most IADLs, with a SLUMS of 21/30, MOCA of 18, and CDR of 3. In the setting of an 88-year-old with progressive memory-predominant cognitive impairment with emerging functional decline, extensive global and hippocampal volume loss, and negative AD biomarkers, a clinical diagnosis of probable LATE was considered. The patient is currently managed on donepezil, escitalopram, and was advised to limit alcohol consumption.

Discussion: AD and LATE have overlapping clinical features and often co-occur, making clinical diagnosis challenging. As amyloid testing increases to meet the demand for amyloid immunotherapy, clinicians will be better equipped to rule out or diagnose LATE that was once only confirmed at autopsy. However, there continues to be no *in vivo* biomarkers or confirmatory way to diagnose LATE outside of autopsy. Therefore, it is imperative to use currently available biomarkers to discuss disease prognosis and guide treatment accordingly, as in this patient who is not a candidate for Lecanemab therapy.

C73 Student Presentation

Low-Dose Radiation Therapy for Peripheral Joint Osteoarthritis: Early Experience in a U.S. Community Oncology Practice

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Background:

Osteoarthritis (OA) is highly prevalent in older adults and contributes to pain, disability, and reduced quality of life. Pharmacologic treatments (NSAIDs, opioids) and surgery carry risks or may be unsuitable for many patients. Low-dose radiation therapy (LDRT) is widely used in Europe but underreported in the U.S. We report early outcomes from a community oncology practice.

Methods:

We retrospectively reviewed 26 patients (51 joints) treated with LDRT for peripheral joint OA between August 2024 and August 2025. Spine and pelvic sites were excluded. Patients received 3 Gy in 6 fractions (0.5 Gy/fraction). Pain was assessed by Numeric Rating Scale (NRS, 0–10) at baseline, end of treatment (EOT), and ~1-month follow-up. Patient-reported global improvement was measured using the von Pannewitz Score (VPS, 0–4). Paired t-tests and one-way ANOVA were used to evaluate outcomes.

Results:

Mean NRS decreased from 8.15 ± 1.4 at baseline to 5.42 ± 1.9 at EOT and 3.50 ± 1.7 at follow-up ($p < 0.001$ at all time points). Responder rate (≥ 2 -point NRS improvement baseline→follow-up) was 84.6%. VPS indicated improvement in 69% at EOT and 92% at follow-up. No $\geq$ Grade 2 toxicities were observed; one patient experienced mild erythema.

Conclusions:

LDRT for OA in a community setting was feasible, safe, and associated with significant pain relief and patient-reported improvement. These findings support LDRT as a potential non-pharmacologic pain management option for older adults with OA.

Mean Pain Scores (NRS 0–10) and VPS Distribution

Timepoint	NRS Mean $\pm$ SD	VPS 0–2 (Improved)	VPS 3 (No Response)
Baseline	8.15 ± 1.4	—	—
End of Treatment	5.42 ± 1.9	69%	31%
Follow-up (~1 mo)	3.50 ± 1.7	92%	8%

NRS = Numeric Rating Scale (0 = no pain, 10 = worst pain).

VPS = von Pannewitz Score (0 = complete relief, 4 = no improvement).

C74 Student Presentation

Improving IOP Monitoring for Older Adults: Evidence on Wearable and Self-Tonometer Technologies

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Background: Glaucoma is a progressive optic neuropathy that leads to irreversible vision loss and disproportionately affects older adults, with prevalence rising sharply after age 60. Clinic-based IOP monitoring inadequately captures fluctuations contributing to progression and limits access for elderly patients with mobility limitations. Wearables and portable IOP monitoring devices offer remote glaucoma monitoring similar to home blood-pressure care models. This systematic review evaluates the accuracy and clinical utility of such devices, including self-tonometry, contact-lens sensors, smartphone-based systems, and biosensors.

Methods: A systematic search of PubMed, Google Scholar, Lens, ClinicalTrials.gov, and grey literature using terms combining glaucoma with wearable or portable monitoring identified human studies with quantitative data on home or ambulatory IOP or visual-function

devices. Analysis included mean bias, Bland–Altman limits of agreement (LoA), and correlation with Goldmann applanation tonometry (GAT), as well as device sensitivity and central corneal thickness (CCT) effects when reported.

Results: Nineteen studies evaluating portable IOP-monitoring devices were included. Clinician-operated rebound tonometers demonstrated excellent agreement with GAT (mean bias 0.11–0.93mmHg; LoA ± 4 to 6 mmHg; ICC 0.74–0.99). Where reported, sensitivity indicated near 1:1 tracking of true IOP changes. Patient-operated home devices showed greater variability (bias 0.4–2.08mmHg; LoA -8.5 to $+5.8$ mmHg). The Tono-Pen XL significantly underestimated IOP (bias -4.1 mmHg, $p=0.02$). CCT significantly influenced measurements across multiple tonometer devices and operator skill ($r=0.30$ – 0.52 , $p<0.05$) with IOP readings increasing by 2.80–3.10mmHg per 100 μ m thicker cornea.

Conclusion: Portable IOP-monitoring devices demonstrate clinically acceptable accuracy. Clinician-operated rebound tonometers can replace GAT and patient-operated devices as adjuncts for detecting IOP trends and peaks. Remote IOP monitoring offers a promising approach to overcome access barriers and capture diurnal fluctuations, with future improvements in device automation and training likely to enhance patient-operated device reliability.

C75 Student Presentation

Wearable and Portable Perimetry for Older Adults With Glaucoma

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Background: Visual field testing is essential for glaucoma monitoring, but standard automated perimetry (SAP), most commonly Humphrey Visual Field (HVF), is time-consuming, fatiguing, and logistically challenging for elderly patients with mobility barriers. Emerging virtual reality (VR), tablet-based, and portable platforms enable assessment outside traditional testing rooms, potentially reducing visit burden and supporting remote care.

Methods: A systematic search of PubMed, Google Scholar, Lens, and ClinicalTrials.gov identified studies evaluating patient use of portable or wearable visual field platforms. Two reviewers screened and extracted data on agreement with SAP, including correlation, mean deviation (MD) bias, Bland–Altman limits of agreement (LoA), test duration, and reliability indices.

Results: Across 36 studies (mean age 42–69 years), most platforms demonstrated strong concordance with SAP despite variation in device design, test algorithms, and testing environments. Three devices showed near equivalence to HVF: Melbourne Rapid Fields (ICC 0.97–0.99), Heru (ICC 0.97), Toronto Portable Perimeter ($r=0.91$). Additionally, these three technologies demonstrated measurement agreement comparable to its test-retest variability (ICC >0.95 , MD bias <1.5 dB). Eight VR/tablet devices showed good agreement to SAP (ICC 0.85–0.94) but had wider LoA. Sensitivity was higher for moderate-to-severe disease (90–100%) than mild disease (67–86%), though monitoring established glaucoma maintained high agreement (ICC 0.85–0.97). Portable devices reduced test times by 2–5 minutes, improved comfort ratings, and demonstrated feasibility for home-based testing in older adults.

Conclusion: Among emerging technologies, Melbourne Rapid Fields, Heru VR perimeter, and Toronto Portable Perimeter demonstrated agreement comparable to SAP test-retest variability, supporting hybrid care models for older adults. However, reduced sensitivity for mild glaucoma limits diagnostic applications. Other VR, tablet, and pupillometry systems demonstrated utility for screening but lack validation for longitudinal monitoring. Further research must prospectively validate progression detection algorithms, develop adherence strategies for older cohorts, particularly those over 75 years, and evaluate the feasibility of self-guided VF monitoring.

C76 Student Presentation

Evaluation of Customized Engagement for Dementia:

A Volunteer-Led Interest Profile Model for Veterans[1] [2]

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Background. Hospitalized Veterans with dementia often show agitation or social withdrawal. Engagement with dementia patients tailored to their abilities and interests reduces behavioral symptoms (Gitlin et al., 2008) and volunteer-supported programs improve hospital outcomes for older adults (Hsieh et al., 2018). The Customized Engagement for Dementia (CED) model fills gaps in volunteer knowledge of patient preferences and communication needs to support interactions. Volunteer-developed Engagement Profiles (EPs) that include information on communication style, activity, music and sensory preferences, and other person-specific information guide interactions. We evaluated volunteer and nurse ratings of Veterans' mood and engagement when volunteers used EPs to guide their visits.

Methods. An exploratory evaluation examined Veteran outcomes in a 6-bed dementia subunit in an acute medical-surgical unit over 8 weeks. After training on CED, volunteers held 1-on-1 engagement sessions and documented observed affect coded as 1=negative to 5=positive before and after sessions; an optional field captured engagement level. Session logs (n=45) from 10 volunteers engaging with 10 Veterans were analyzed using non-parametric statistics. Nurse surveys rated Veteran affect after volunteer engagement sessions. EPs were coded qualitatively to identify key topics, interests, and triggers.

Results. EPs were used in 29/45 (64%) of sessions. Volunteer-reported mean mood for sessions using EPs increased significantly from 2.3 at the start of sessions to 3.5 at the end (Wilcoxon Signed-Rank Test, $p=0.00034$). Of sessions using EPs, 86% noted strong engagement levels from Veterans. Key topics extracted from profiles included the importance of military service stories, music, family/care-giver roles, sports, and cars while also showing meaningful variation among individuals. Nurse feedback supported the volunteer reports, with all respondents (n=12) noting that Veterans were in a "better" or "much better" mood after EP guided volunteer engagement.

Conclusions. A volunteer-led, CED model is associated with short-term improvements in mood and engagement among hospitalized Veterans with dementia. EPs offered practical guidance that supported individualized volunteer interactions. Results will be used to refine the CED model for future scaling.

C77 Student Presentation

Implementation of an Advanced Care Planning Protocol: Impact on Patient Understanding and Completion of Advanced Care Directives

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Advanced directives are recommended for all adults; however, in the United States, only approximately 37% of adults have completed the documentation (Quinn et al., 2022). Primary care providers are uniquely able to leverage the established, collaborative relationship that they have with patients to best educate them. For providers to initiate this discussion, they must have confidence and feel comfortable speaking on the topic.

Methods

This proposed project was conducted as a single-center study within an NP independently owned primary care practice in a suburb of Rochester, New York, established in 2022. Institutional Review Board (IRB) approval was obtained. A quantitative descriptive design was utilized with an aim of increasing both patient and provider understanding of advanced directives, provider confidence in discussions, as well as increasing the overall completion rate of advanced directives. The Provider pre- and post-survey data were analyzed using descriptive statistics. Patient pre- and post-survey data were analyzed using

descriptive statistics and a paired t-test. For the individual survey questions, a Wilcoxon test was utilized. All data was analyzed using Microsoft Excel version 2502 and Intellectus Statistics version 4.8.

Results

A two-tailed paired t-test and Wilcoxon Signed Rank analyses demonstrated highly significant improvements in patient understanding of advanced care planning, with all survey items showing post-intervention increases ranging from 14.7% to 117% ($p < .001$). Advanced directive completion rose from 0% to 66.2% within the study sample and increased by 506% across the full practice panel, accompanied by substantial growth in ACP billing code use.

As a result of the intervention, more patients gained knowledge and confidence in understanding and completing advanced directives. Providers became more comfortable initiating these important discussions and demonstrated increased completion of proper documentation.

C78 Student Presentation

Co-Designing an Augmented Reality (AR) System for Fall Prevention: A Mixed-Methods Evaluation

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Background

Falls affect 1 in 4 older adults (OAs) annually, with fall-related mortality rising 41% from 2012-2021 in the U.S. Functional balance training can reduce fall risk and AR-based interventions show potential as accessible home-based programs. This study explores the preferences and usability needs of OAs and healthcare professionals (HCPs) to guide AR prototype refinement.

Methods

A convergent mixed-methods study was conducted with community-dwelling OAs (n=18; ≥ 60 years) and HCPs (n=19) recruited via purposeful snowball sampling until data saturation. Six focus groups (3 OAs, 3 HCPs) were conducted and guided by the Design Thinking Framework, and analyzed using directed thematic analysis. Participants completed the System Usability Scale (SUS; 10 items, 5-pt scale), Technology Acceptance Model (TAM; 6 items on Perceived Usefulness (PU) and Perceived Ease of Use (PEU) each, 7-pt scale), and Net Promoter Score (NPS; 1 item, 10-pt scale). Quantitative data was analyzed using descriptive statistics, linear regressions, and chi-squared tests.

Results

Five themes were identified to guide refinement: (1) Make it easy: ease-of-use, safety, practicality; (2) Make it matter: adding clinical decision points and avatar personalization; (3) Make it personal: customizable goal-setting and feedback, and language adaptations; (4) Make it social: gamification and social engagement; (5) Make it affordable: reduced costs and privacy burdens, and rural applications. Quantitative data analysis revealed no significant group differences. SUS scores scaled 0-100 indicated moderate usability (HCP: (mean $\pm$ SD) 57.1 $\pm$ 10.8; OA: 59.0 $\pm$ 14.5). TAM PU scores were modest (HCP: 3.58 $\pm$ 0.97; OA: 3.38 $\pm$ 1.40), and PEU scores were low-moderate (HCP: 2.62 $\pm$ 1.03; OA: 3.17 $\pm$ 1.45). NPS scores were moderate (HCP: 6.16 $\pm$ 1.46; OA: 4.94 $\pm$ 2.92).

Conclusions

The home-based AR balance training system shows moderate acceptability and potential for adoption provided refinements address ease-of-use, customization, and accessibility. Findings will inform system improvements to enhance adoption among OAs and HCPs.

C79 Student Presentation

Sex and Racial Disparities in AI-Based POCUS Screening for Structural Heart Disease in Geriatrics Clinic

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Background: The prevalence of structural heart disease (SHD, defined as valvular heart disease (VHD) or left ventricular systolic dysfunction [LVSD]) increases with age. Women and racial/ethnic minority populations experience significantly higher rates of non-referral and delayed referral for further management. There remains a critical need for systematic screening to facilitate early detection of SHD in higher-risk older adults and to mitigate these sex- and race-based disparities.

Methods: Adults aged 65-85 years old without known VHD or an echocardiogram in the last 5 years were enrolled from two geriatric primary care clinics (academic and safety-net) at our institution. Medical assistants and medical students performed AI-POCUS after brief device-specific training; images were analyzed by a blinded echocardiography core laboratory. The primary outcome was the detection rate of SHD ($\geq$ moderate aortic or mitral VHD or LVSD) based on self-reported sex and race.

Results: A total of 183 participants were enrolled between March-August 2025 (median age 79.6 years, 67% women, 22% non-White); 165 scans (90.7%) were deemed adequate for analysis by the echocardiography core lab. Among these 165 participants, SHD was present in 12.1% overall (6.1% $\geq$ moderate aortic or mitral VHD; 6.7% LVSD). Sex- and race-based detection rates are outlined in the Table.

Conclusions: AI-POCUS performed by non-experts in outpatient primary care is feasible and identifies substantial previously unrecognized VHD and other structural disease, with notably higher detection of clinically significant VHD in women. Systematic screening using AI-POCUS may help reduce sex- and race-related barriers to timely SHD evaluation in older adults.

	Overall (n=165)	Men (n=54)	Women (n=111)	p-value	Non-Hispanic White (n=116)	Hispanic White (n=13)	Black (n=27)	Other (n=9)	p-value
SHD	20 (12%)	3 (5.6%)	17 (15%)	0.071	12 (10%)	1 (7.7%)	5 (19%)	2 (22%)	0.5
VHD	10 (6.1%)	0 (0%)	10 (9.0%)	0.031	6 (5.2%)	1 (7.7%)	2 (7.4%)	1 (11%)	0.4
LVSD	11 (6.7%)	3 (5.6%)	8 (7.2%)	0.9	7 (6.0%)	0 (0%)	3 (11%)	1 (11%)	0.4

C80 Student Presentation

The Double Care Partner Role: Care Partners of patients with dual diagnoses of dementia and cancer

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Background: Older adults with dementia and cancer experience complex treatment decisions that rely on care partners (CP). Despite their central role, little is known about CP supporting patients with dual diagnoses. We prospectively enrolled CPs of patients with dementia and cancer to evaluate a geriatric assessment (GA)-based communication intervention (COACH-Cog).

Methods: Patient-CP dyads were enrolled in this single-arm, feasibility study (NCT06313853). The COACH-Cog intervention included: 1) providing CP with the patient's GA summary; 2) a communication coaching session to help CP articulate concerns related to the patient's dementia in the context of cancer and identify questions for the oncology care team. The CP baseline assessment included the Borgatta Caregiver Burden Scale (BCBS), measuring objective, subjective,

and demand burden; PROMIS Depression and Anxiety; and the WHOQOL-BREF (physical, psychological, social, and environmental domains). Acceptability of Intervention Measure (AIM) was assessed post-intervention. Raw scores and domain means were calculated per participant and summarized using descriptive statistics.

Results: Ten CPs (mean age 74.3; 80% female) were enrolled. BCBS scores indicated moderate burden: while CPs experienced measurable emotional and role-related stress, objective disruptions in daily activities were low (Table 1). PROMIS Depression and Anxiety scores indicated mild to moderate emotional distress. CP quality-of-life (WHOQOL-BREF) scores suggest good environmental and physical functioning but poor social functioning. Mean AIM score was 50.3, reflecting high intervention acceptability.

Conclusions: Collectively, these findings demonstrate that while CPs maintain a good quality of life (QOL), they also experience emotional and role-related stress, underscoring the need for targeted interventions for this population.

Table 1. Descriptive Characteristics of Care Partners (n = 10)

Measure	Mean (SD)	Range	Interpretation/Notes
Age (years)	74.3(14.8)	40-90	Majority female (80%), primarily spouses or adult children
AIM	50.2(8.2)	37-60	High intervention acceptability
Objective Burden	12(2.9)	3-15	Minimal caregiving demands
Subjective Stress	15(4.8)	4-20	High emotional strain
Subjective Demand	10(6.1)	4-15	Moderate perceived time/effort demands
PROMIS Depression (Raw)	8.4(2.1)	5-12	T-Score (SE*)=55.7(2.3) Mild to moderate depressive symptoms
PROMIS Anxiety (Raw)	7.4(1.1)	5-9	T-Score (SE*)=53.7(2.8) Mild to moderate anxiety symptoms
WHOQOL-BREF	34.7(5.2)	14-32	WHOQOL Transformed Scores (0-100 scale) Physical-63.7 Psychological-57.9 Social-48.3 Environmental-75.9
Physical	19.9(4.2)	13-26	
Psychological	8.8(2.1)	4-10	
Social	32.3(4.1)	27-37	
Environmental			Overall good QOL with strong environmental and physical functioning; moderate QOL in psychological well-being and comparatively weaker social QOL.

C81 Student Presentation

Sleep variables in agitated Alzheimer's patients: effect of escitalopram

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Background: In Alzheimer's disease (AD), sleep disturbance and agitation, a neuropsychiatric symptom, are common. However, the relationship between sleep and agitation as determined by objective measures like actigraphy remains unclear. In this study, ancillary to the Escitalopram for Agitation in AD (S-CitAD) study, we aimed to assess the effect of escitalopram on change in sleep parameters from baseline (BL) and the relationship between sleep parameters and agitation. **Methods:** 32 participants (age=79 $\pm$ 9.93 years, 43.7% female, 12.5% non-White) of the 173 participants of S-CitAD, a 12-week randomized controlled trial evaluating escitalopram's effect on agitation in AD, had actigraphy. Sleep parameters measured were awakening length, number of awakenings, efficiency, fragmentation index, latency, total activity counts during sleep, total minutes in bed, total sleep time, and wake after sleep onset. Agitation was measured with the Neuropsychiatric Inventory-Clinician rating scale Agitation and Aggression (NPI-C A+A) domains. **Results:** 9 of the 32 participants had both BL and 12-week follow-up (f/u) data. Mean NPI-C A+A at BL was 16.0 $\pm$ 6.18. Sleep had no significant association with change in agitation at f/u or with agitation at BL. The effect of escitalopram on sleep parameters at f/u was not significant for all parameters except

latency ($p=0.05$) and total minutes in bed ($p=0.05$). Responders, those with moderate or marked improvement in agitation at f/u, had a significantly lower reduction in sleep latency at f/u compared to non-responders ($p=0.002$). BL fragmentation index ($p=0.039$), movement index ($p=0.007$), and sleep fragmentation index ($p=0.013$) were significantly higher in responders than in non-responders. **Conclusions:** There was no association between sleep parameters and BL agitation or change in agitation, and escitalopram treatment did not significantly affect sleep parameters or agitation. These data will help provide direction for future studies of agitation in AD.

C82 Student Presentation

Fall Risk Increasing Drugs are Underutilized Deprescribing Targets in SNF Patients with Fracture: The PRISM Trial

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Deprescribing fall related injury inducing drugs(FRIID) is an underutilized, evidence-based practice for preventing injury and reducing mortality in skilled nursing facilities(SNF). The Prevention of Injury in SNFs through Medication Optimization(PRISM) is a cluster randomized trial comparing injurious fall rates in deprescribing and non-deprescribing care models for post-fracture SNF patients. This study examines FRIID incidence and deprescribing recommendations among patients enrolled.

Patients were enrolled between 10/2024-7/2025 with the following inclusion criteria: age ≥ 65 years, admission to enrolled SNF after hospitalized fracture, and medication optimization plan(MOP) completion before discharge. FRIIDs included medications that increase fall risk (e.g., alpha-blockers, psychotropics) or fall-related injury (proton-pump inhibitors(PPI)). Medication indications were determined through electronic health record review by a nurse consultant, who determined deprescribing targets using an evidence-based algorithm with geriatrician support. The MOP was finalized after the nurse spoke with the patient/representative.

656 patients were included. 69.8% were female. Mean age was 82 years(range 65–101). 34.1% had hip fractures. Mean number of FRIIDs was 2.5. The most common FRIIDs were antihypertensives(46.6%), antidepressants(38.0%), PPIs(35.1%), and anticholinergics(28.0%). The most common FRIIDs with tapers in the final MOP were anticholinergics(71.7%), sedative-hypnotics(80.0%), and PPIs(63.5%).

Anticholinergics and PPIs are good deprescribing targets in patients recovering from fracture in a SNF

Medication Class	Number (%) of patients taking 1+ deprescribing targets	Number (%) of patients suitable for deprescribing	Number (%) of patients with deprescribing recommendations
Alpha Blockers	16 (2.4)	8 (50.0)	7 (43.8)
Beta Blockers	247 (37.7)	45 (18.2)	19 (15.8)
Antihypertensives	306 (46.6)	105 (34.3)	83 (27.1)
Anticholinergics	184 (28.0)	153 (83.2)	132 (71.7)
Anxiolytics	76 (11.6)	46 (60.5)	30 (39.5)
Antidepressants	249 (38.0)	93 (37.3)	74 (29.7)
Antipsychotics	27 (5.6)	15 (40.5)	10 (27.02)
Sedative-hypnotics	10 (1.5)	9 (90.0)	8 (80.0)
Dementia	120 (18.3)	72 (60.0)	56 (46.7)
Gabapentin	93 (14.2)	63 (67.7)	47 (48.0)
PPIs	230 (35.1)	167 (72.6)	146 (85.5)
Nonsteroidal anti-inflammatories	93 (14.2)	48 (51.6)	44 (47.3)

*** of patients suitable for deprescribing determined by dividing # of patients with indications supporting taper by # of patients prescribed FRIIDs
 % of patients with MOP recommendations defined as # of patients with a FRIID taper in final MOP divided by # of patients prescribed FRIIDs

C83 Student Presentation

Lag Time to Benefit? Long-Term Outcomes of the 5-Cog Paradigm To Improve Dementia Care in Primary Care

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Background: Dementia is underdiagnosed and disproportionately so among individuals from historically minoritized backgrounds. The 5-Cog is a paradigm combining a novel brief cognitive assessment with clinical decision support. In a randomized controlled trial (RCT) of 1201 diverse older adults with cognitive concerns in a primary care clinic, the 5-Cog showed improved dementia care in a 90-day period. Given competing demands and time constraints in primary care settings, 90 days may not have been long enough to reach full benefit. Longer-term outcomes of the 5-Cog paradigm have not been assessed.

Methods: Charts of the 152 RCT patients who had dementia-relevant actions by 90 days were reviewed for additional outcomes (cognitive impairment diagnosis; lab or imaging workup orders; dementia specialist or community-based organization referrals; and dementia medication prescriptions) from original 5-Cog enrollment (rolling dates between 2019 and 2022) and up to January 31, 2025. Outcomes were categorized by time met: within 90 days, between 91 days and 1 year, and after 1 year. SPSS-30 was used for analysis.

Results: Mean age was 75.7 years; 69.7% were females, and 61.8% spoke primarily Spanish. Thirteen (8.5%) patients died during the follow up period. Twenty-nine (19.1%) had an additional outcome between 91 days and 1 year, and 56 (36.8%) after a year. Overall, there were 183 total outcomes after 90 days, among 64 (42.1%) patients. The most common additional outcome after 90 days was specialist referral ($n=40$, 26.3%). Among all patients who received a mild cognitive impairment or dementia diagnosis at some point during follow up ($n=99$, 65.1%), 21 (21.2%) received it for the first time after 90 days.

Conclusion: Among patients whose providers took some dementia-relevant action during their 5-Cog visit, nearly half received additional actions after 90 days. Trends in outcomes before and after 90 days may reflect varying levels of primary care provider (PCP) comfort with dementia-relevant actions, PCP triage decisions, and administrative delays to accessing specialist care. We will determine rates of PCP re-visit within 90 days and review long-term outcomes in the entire cohort to confirm these trends.

C84 Student Presentation

Revised Disease Risk Index (rDRI) as a Prognostic Tool for Post-Transplant Survival in Hematologic Malignancies: A Retrospective Analysis at Johns Hopkins

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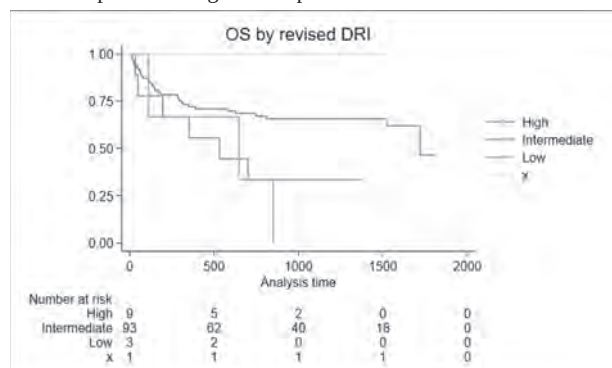
Objective: The refined Disease Risk Index (rDRI), as proposed by Dr. Armand, was developed to improve risk stratification for patients undergoing allogeneic hematopoietic stem cell transplantation (allo-HCT) based on disease type, cytogenetic risk, and remission status. This study applied the rDRI to a retrospective cohort to assess its prognostic utility in predicting post-transplant overall survival (OS) in a real-world clinical setting.

Methods: We conducted a retrospective analysis of 106 patients who underwent allo-HCT at The Johns Hopkins Hospital. Patients were classified into rDRI risk groups (low, intermediate, high, very high) according to the criteria outlined by Dr. Armand's model. OS was estimated using Kaplan-Meier survival analysis, with time-to-event defined from transplant to death or last follow-up.

Results: Of the 106 patients, 93 were classified as intermediate risk, 9 as high risk, and 3 as low risk. One patient could not be classified due to an unrepresented disease type. Kaplan-Meier curves demonstrated clear OS stratification by rDRI, with high-risk patients

exhibiting the poorest survival, characterized by a steep decline within the first 1,000 days post-transplant. Intermediate-risk patients had superior OS compared to high-risk patients but showed a progressive decline over time. The low-risk group did not demonstrate better outcomes, likely due to limited sample size.

Conclusion: The rDRI effectively stratifies post-transplant OS in patients with hematologic malignancies, supporting its prognostic value. The poor survival of high-risk patients underscores the need for novel therapeutic strategies to improve outcomes in this cohort.



C85 Student Presentation

The Relationship Between Time Perception and Cognitive Function in Older Adults: An Observational Pilot Study

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Background:

Cognitive conditions, such as dementia, delirium, anxiety, and depression, may alter subjective time perception. The study's objective is to better understand how time estimation varies across cognitive and psychiatric conditions.

Methods:

In this observational pilot study, participants aged ≥ 65 were recruited from a geriatric and memory disorder clinic. They were stratified by Mini-Cog (MC) score into a cognitively intact (C) group (score 4-5) and a cognitively impaired (CI) group (score 1-3). A standardized stopwatch test was conducted by asking the participants to stop the timer at 1 minute. Ten consecutive trials were recorded for each participant to assess estimation accuracy and within-person consistency. Clinical variables collected included the MC, Patient Health, and Generalized Anxiety Disorder Questionnaires, as well as medical comorbidities. The primary outcomes were the mean stopwatch deviation from 1 minute and the number of trials required to reach consistent performance. Secondary analyses explored correlations between time-duration estimation deficits and cognitive measures.

Results:

The CI group was older (median 81 years, IQR 75-84) than the C (77, 72-79). On the time-estimation task, CI patients showed lower mean time estimations (29 seconds, IQR 19-48) than C (57 seconds, IQR 42-73; Wilcoxon $p < 0.001$). The CI group also had a larger negative deviation from the target time (mean deviation: -31 seconds; IQR: -41 to -12 vs. -3s, -18 to 13; $p < 0.001$). The C group shows improvement in time estimation, on subsequent trials, closer to the target time. The effects of anxiety and depression were inconclusive.

Conclusion:

Individuals with CI demonstrated a tendency to be inaccurate and inconsistent in their personal estimation of time's passage. Results can inform future larger-scale studies assessing whether time-perception metrics could serve as a simple adjunctive clinical marker for CI.

C86 Student Presentation

Depression, Anxiety, and Medication Burden as Key Predictors of the Drug Burden Index in Older Adults

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Background: The Drug Burden Index (DBI) quantifies exposure to anticholinergic and sedative/hypnotic medications and is associated with adverse outcomes in older adults. Although DBI has been described in several populations, prior studies have not comprehensively considered how demographic, medical, and cognitive factors contribute to DBI. This study examined these factors among older adults enrolled in the Medicare Chronic Care Management (CCM) program.

Methods: This retrospective cohort of primary care patients aged ≥ 65 years with multiple comorbidities were required to have a documented Annual Wellness Visit, Cognitive Assessment and Care Plan Visit within the past year. DBI was calculated using the original Hilmer et al. (2007) DBI equation with an updated 2025 medication list. DBI was dichotomized at the cohort median to classify patients as having low versus high DBI. Univariate logistic regression analyses evaluated associations between DBI category and demographic, medical, and cognitive variables; those with $p < 0.2$ advanced to multivariable logistic regression. Odds ratios (ORs), 95% confidence intervals (CIs), and p-values were reported. Analyses were conducted in Minitab (version 22.4), with $p < 0.05$ considered significant.

Results: Of 390 patients screened, 75 (20%) met inclusion criteria. The median DBI was 0.5. In univariate analyses, depression, anxiety, insomnia, urinary incontinence, and medication load were associated with high DBI. In multivariable analysis, only depression (OR 6.7; 95% CI 2.2-20.4; $p = 0.001$) and anxiety (OR 3.9; 95% CI 1.2-12.4; $p = 0.022$) remained significantly associated. Coexisting depression and anxiety markedly increased the odds of high DBI (OR 21.8; 95% CI 2.7-179; $p = 0.004$). No demographic characteristics, cognitive assessment findings, fall-risk history, or other multimorbidity combinations were associated with DBI. Medication load was significantly associated with high DBI (OR: 1.23; [1.11-1.38]; $p \leq 0.001$).

Conclusion: Depression and anxiety diagnoses were each significantly associated with having a high DBI. Having both diagnoses together was associated with the greatest odds for a high DBI. These conditions and the total number of medications should be prioritized when identifying older adults most likely to benefit from pharmacist-led CCM medication review and deprescribing interventions.

C87 Student Presentation

Positive Affect and Onset of Cognitive Impairment in Older Mexican Americans: Findings from a Longitudinal Study

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Background: Cognitive impairment (CI) is a known precursor to Alzheimer's disease and other dementias. Recent studies have shown positive affect (PA) to be associated with lower rates of CI. This study examined the association between PA and CI among Mexican American adults aged 75 and older with cognitive function in the normal range at baseline (2004/2005).

Methods: Participants ($n = 976$) were from the Hispanic Established Population for the Epidemiological Study of the Elderly (2004/05-2016). Measures included socio-demographics, language of interview, body mass index, multi-morbidity, negative affect, pain, and falls. Participants who scored below 21 on the Mini-Mental State Examination at follow-up were classified as having CI. PA was assessed using four items from the Center for Epidemiologic Studies Depression scale.

Results: Participants were categorized into four PA quartiles: 0-<8 (n=129), 8-<10 (n=201), 10-<12 (n=214), and 12 (n=432). Generalized estimating equations were used to estimate the odds ratio (OR) and 95% confidence limits (CL) of CI over time across PA quartiles, controlling for covariates. Participants in the 2nd, 3rd, and 4th PA quartiles had lower odds (OR=0.47, 95% CL=0.32-0.68, OR=0.37, CL=0.24-0.55, and OR=0.31, 95% CL=0.21-0.47, respectively) of developing CI over time than those in the 1st PA quartile.

Conclusions: Association of higher levels of PA with decreased risk of CI over time suggests a need to develop PA-enhancing interventions. Increasing participation in culturally responsive activities known to boost PA, such as social and community events, stress management practices, culturally meaningful and purposeful activities, and cognitive stimulation, may help mitigate the onset of CI and dementia in older Mexican American adults, a rapidly growing segment of the U.S. older adult population.

C88 Student Presentation

Describing Social Determinants in the Dementia Research, Education, and Advancement in Los Angeles (DREAM-LA) Clinical Study

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Background: Though Black/African American and Hispanic/Latinx communities bear a disproportionate burden of disease for Alzheimer's Disease and Related Dementias (ADRD), most ADRD research has focused on non-Hispanic White populations, leaving the relationship between social determinants and ADRD in minority populations understudied¹.

Methods: Through a multi-center, three-tiered observational design with increasing levels of involvement and compensation, the Dementia Research, Education, and Advancement in Los Angeles (DREAM-LA) clinical study aims to develop a comprehensive database of biological, social, and environmental factors associated with ADRD in underrepresented populations throughout Los Angeles County. Participant's social determinants of health (SDOH) are assessed through survey responses. For this study, our objective was to analyze how SDOH are associated with tiered recruitment preference and cognitive status.

Results: As of July 2025, 95 participants from Hispanic/Latinx, Black/African American, and Asian American Native Hawaiian Pacific Islander racial and ethnic groups were enrolled in DREAM-LA. Our results suggest that self-described socioeconomic status did not differ by participant tier (Kruskal-Wallis, $p = 0.1649$). However, some tiers differed in language, race (Fisher exact, $p < 0.004$), and access to transportation (Fisher exact, $p = 0.004$). Participants were stratified by Mini-Mental State Examination (MMSE) score into two groups: ≤ 24 and ≥ 25 . SDOH that differed significantly between the groups included marital status (FDR-adjusted $p = 0.0145$), living situation (FDR-adjusted $p = 0.0464$) and medication nonadherence due to cost (FDR-adjusted $p = 0.0464$).

Conclusion: Differences in race, language, transportation access, and other SDOH factors across tiers and MMSE groups highlight the need for adequate translation support and transportation assistance, and broader attention to social context as contributors to cognitive status in underrepresented communities.

1. Mooldijk SS, Licher S, Wolters FJ. Characterizing Demographic, Racial, and Geographic Diversity in Dementia Research: A Systematic Review. *JAMA Neurol.* 2021;78(10):1255-1261. doi:10.1001/jamaneurol.2021.2943

C89 Student Presentation

Cross-National Assessment of Intrinsic Capacity Among Older Adults: Harmonized Analysis Across Seven Aging Cohorts

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Background:

Intrinsic Capacity (IC) provides a multidimensional view of older adults' health, yet cross-national comparisons are limited by inconsistent measurements and reliance on summary scores that mask functional heterogeneity. We harmonized IC measures across diverse global cohorts to identify functional aging profiles and examine social and health determinants.

Methods:

We analyzed harmonized data from seven longitudinal studies—HRS, ELSA, SHARE, KLoSA, CHARLS, MHAS, and LASI—totaling 82,839 adults aged ≥ 60 years from 35 countries. Standardized IC domains (cognition, psychological health, sensory function, vitality, and locomotion) were constructed using comparable indicators. Principal Component Analysis and K-means clustering identified aging profiles. Multinomial logistic regression examined associations with sociodemographic characteristics and chronic disease burden.

Results:

Three profiles were identified. *Successful Aging* (38%) demonstrated high performance across all IC domains and was associated with higher education, stronger socioeconomic conditions, and fewer chronic conditions. *Comprehensive Frailty* (31%) showed deficits across domains - especially vitality and locomotion - and was linked to multimorbidity and socioeconomic disadvantage. *Compensatory Aging* (30%) featured relatively preserved cognition alongside lower functioning in other domains and was more prevalent among socially vulnerable groups. High-income countries had higher proportions of Successful Aging, whereas middle-income countries showed more Compensatory Aging.

Conclusions:

Cross-national harmonization of IC reveals substantial heterogeneity in functional aging and underscores the importance of social and health determinants. IC offers a unified framework for understanding variations in aging across countries and supports policies that strengthen resilience, reduce socioeconomic disparities, and promote multidimensional healthy aging.

C90 Student Presentation, Encore Presentation

Prevalence of foot and ankle osteoarthritis: The Johnston County Health Study

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Osteoarthritis (OA) is a leading cause of disability and is estimated to affect 90 million people in the U.S. While much of OA research is focused on hip and knee OA, few studies have been focused on foot or ankle OA, despite their major impact on function and quality of life. Our purpose was to describe the prevalence of ankle and foot symptoms and radiographic and symptomatic osteoarthritis (rOA and sxOA, respectively) in a population-based cohort in the southeastern U.S. This addresses research gaps identified by the International Ankle and Foot Osteoarthritis Consortium.

Adults (n=902) aged 35-70 years were enrolled from Johnston County, NC. Participants provided demographic information, weight-bearing radiographs to evaluate presence of ankle or foot OA, and questionnaires on medical history, symptoms, pain, function, and quality of life. Survey-weighted proportions and 95% confidence intervals were calculated to examine prevalence overall and by subgroups.

Ankle and foot rOA were present in 1 in 10 and 1 in 7 participants, respectively, with a higher prevalence in older age and those

with obesity or diabetes. Ankle rOA was more prevalent in males, but foot rOA showed no sex differences. Participants with ankle or foot sOA had at least five times higher odds of poorer quality of life compared to participants without ankle or foot sOA. Only midfoot rOA was more prevalent among Black participants compared to White participants.

Foot and ankle OA are highly prevalent among 35–70-year-olds and have a major impact on function and quality of life. These data inform medical providers of the high frequency of foot and ankle OA, while supporting conversations regarding important aspects of care. Further research is necessary to explore the mechanisms behind sex differences observed in this study and how best to address quality of life measures.

	Ankle rOA	Ankle sOA	Foot rOA	Foot sOA	1st MTP rOA	Midfoot rOA
All participants	10.4 (8.0, 12.8)	3.8 (2.4, 5.2)	15.6 (13.0, 18.2)	8.2 (6.2, 10.3)	8.1 (6.1, 10.1)	9.0 (7.0, 10.9)
Female	8.8 (6.1, 11.5)	4.2 (2.2, 6.2)	15.1 (11.9, 18.3)	8.5 (5.9, 11.1)	7.2 (4.8, 9.7)	9.7 (7.2, 12.1)
Male	12.4 (8.2, 16.6)	3.4 (1.3, 5.4)	16.2 (11.8, 20.6)	7.9 (4.7, 11.0)	9.1 (5.6, 12.6)	8.1 (5.0, 11.2)
BMI, kg/m ²						
Normal (18.5–24.9)	5.7 (1.3, 10.2)	2.9 (0.2, 5.5)	10.0 (3.7, 16.4)	6.3 (0.7, 11.9)	8.4 (2.2, 14.5)	ne
Overweight (25–29.9)	7.3 (3.0, 11.3)	ne	10.3 (6.3, 14.2)	5.9 (2.8, 8.9)	7.4 (3.9, 10.9)	3.6 (1.2, 6.0)
Class I/II obesity (30–39.9)	9.1 (5.7, 12.6)	3.8 (1.4, 6.2)	18.9 (14.3, 23.6)	9.0 (5.5, 12.6)	9.8 (6.2, 13.3)	10.8 (7.4, 14.1)
Class III obesity (>40)	21.8 (14.5, 29.0)	7.8 (3.6, 12.0)	19.6 (13.4, 25.7)	11.3 (6.7, 15.9)	5.0 (1.6, 8.3)	17.3 (11.5, 23.2)
Diabetes (n=9)						
No diabetes or diet controlled	9.8 (7.2, 12.4)	3.9 (2.3, 5.6)	13.7 (11.0, 16.4)	6.4 (4.6, 8.2)	7.0 (5.0, 9.0)	8.0 (5.9, 10.1)
Diabetes	13.7 (7.2, 20.1)	3.7 (1.1, 6.2)	23.9 (16.3, 31.5)	16.1 (8.9, 23.2)	12.4 (5.6, 19.2)	13.7 (8.6, 18.9)

Prevalence estimates (%) and corresponding 95% confidence intervals (CI) weighted to the 2020 US Census target population by sex, body mass index (BMI) group, and diabetes status.

C91 Student Presentation

Association between cumulative anticholinergic and sedative medications and measures of physical functioning: data from the Canadian Longitudinal Study on Aging (CLSA)

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Background: The cumulative use of anticholinergic and sedative medications has been associated with impaired physical functioning in older adults. This study aimed to identify which physical function attributes are most impacted and assessed these associations in subgroups aged 45–64 and 65–85 years.

Methods: Baseline (2011–2015) data from 30,097 community-living Canadians in the CLSA were analysed cross-sectionally. Cumulative anticholinergic and sedative medications use was quantified using the Drug Burden Index (DBI). Physical functioning was measured via five performance-based tests: timed 4-meter walk, Timed Up and Go (TUG), single leg balance, chair rise and grip strength, which served for latent profile analysis. Associations between DBI scores and physical function were assessed through linear regression of standardized scores of the five tests and multinomial logistic regression for latent physical functioning profiles.

Results: The mean age of participants was 63.0, 50.9% were female, 5,520 (18.3%) had a DBI score 0<DBI<1 and 2,613 (8.7%) a DBI score ≥1. Adjusted regression models showed the greatest reduction in standardized scores for the TUG test among participants with DBI ≥1 (β: -6.05; 95% confidence interval: -6.77 to -5.33) relative to DBI =0. Latent profile analysis indicated that the two profiles with

the poorest physical functioning were significantly associated with higher odds of exposure to both DBI categories, whereas the profile reflecting the best functioning was associated with reduced odds of DBI ≥1. Associations of similar magnitude were observed across age strata (45–64 and 65–85 years).

Conclusions: Cumulative anticholinergic and sedative medication burden was inversely associated with physical functioning. These findings were consistent across standardized scores for performance-based tests and latent profile analysis, with similar effects observed in middle-aged and older adults.

C92 Student Presentation

Social Engagement and Emotional Well-Being in Community-Dwelling Older Adults pre- and post-COVID-19 Pandemic

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Background:

Social engagement is a core component of successful aging, especially for older adults at risk of isolation. However, interpersonal connections were disrupted by the COVID-19 pandemic. This study explored whether the relationship between social engagement and emotional well-being changed from pre- (2019) to post-pandemic (2023) in community-dwelling older adults.

Methods:

Data from 230 participants in both 2019 and 2023 were examined. Participants were excluded if they were not aged 50+ in both years or did not fully complete all scales used in the analysis. Linear mixed effects regression models examined associations between social engagement and six emotional outcomes (happiness, optimism, wisdom, resilience, anxiety, and depression). Each of the six models included main effects for the covariates age, gender, and marital status, as well as two-way interaction effects between social engagement and survey year, gender, and marital status.

Results:

Of the 230 participants, 53.5% were male, 86.1% were White, and the mean age in 2019 was 69.38 years. Between 2019 and 2023, social engagement, optimism, wisdom, and resilience significantly decreased while anxiety significantly increased. Social engagement was positively associated with happiness, optimism, wisdom, and resilience, and negatively associated with anxiety and depression. The strength of associations between social engagement and happiness, optimism, resilience, and anxiety significantly weakened between 2019 and 2023. Older individuals or married individuals showed greater happiness, and married individuals had lower depressive symptoms.

Conclusions:

To our knowledge, this is the first study comparing associations between social engagement and emotional well-being from pre- and post-COVID-19 periods. It is likely that disruptions from the COVID-19 pandemic introduced or affected factors moderating the associations between social engagement and emotional well-being, resulting in a decreased protective effect of social engagement for robust mental health after the pandemic.

C93 Student Presentation

Associations Between Living Alone, Social and Physical Activities, and Loneliness: Examining Heterogeneity by Race/Ethnicity

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Background: Loneliness in late adulthood is linked to a range of health risks, such as dementia, sleep disorder, heart disease, stroke, obesity, and increased mortality. Social and physical activities help reduce loneliness among older adults, especially those living alone. Yet little is known about how activity engagement relates to loneliness symptoms among solo-living U.S. older men and women across different racial and ethnic groups, particularly in the post-pandemic period.

Methods: This longitudinal study examines the relationships between activity engagement (vigorous activity, visiting friends/family, religious services attendance, volunteering, and walking) in relation to race and ethnicity and loneliness among 3,972 Americans aged 65 and over who live alone. Using the 2021-2023 National Health and Aging Trends Study (NHATS) and mixed-effects logistic regressions, we examined associations between activity engagement and loneliness by race, ethnicity, and sex, accounting for sociodemographic, health, and other characteristics.

Results: Bivariate analyses revealed that non-Hispanic (NH) Black participants had higher rates of attending religious services (62.6%) than their NH White and Hispanic peers, but this association was not significant in the multilevel logistic models. In multivariate analyses, men who attended religious services had significantly increased odds of experiencing loneliness (OR = 2.59), regardless of race/ethnicity. Compared to NH White counterparts, Hispanic participants who engaged in vigorous activity (OR = 4.20) or visiting friends/family (OR = 3.21) had significantly greater odds of feeling lonely. This pattern was more pronounced among Hispanic women, who had significantly greater odds of loneliness (OR = 6.37) than did NH White women. Among Hispanic men, visiting friends/family was associated with greater, though non-significant, odds of loneliness (OR = 5.08) compared with NH White men.

Conclusion: Among older U.S. men and women living alone, race-ethnicity in conjunction with social and physical activity involvement may lead to differential impacts on their loneliness outcomes and underscoring the importance of the development of race-ethnicity-specific interventions.

C94 Student Presentation

Social Isolation and Loneliness Among Older Adults with Opioid Use Disorder

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Background: Social isolation and loneliness have lasting, negative impacts on physical and mental health. For those with opioid use disorder (OUD), social isolation and loneliness may lead to decreased treatment engagement and increased psychoactive substance use. Little research has explored the intersection of aging, OUD, and social connectedness.

Methods: We recruited adults aged ≥ 55 from opioid treatment programs in San Diego County. Participants completed a cross-sectional survey that collected sociodemographic data, past 30-day psychoactive substance use, PHQ-9 to measure current depressive symptoms, and past 6-month emergency department (ED) utilization. Participants then completed the Berkman-Syme Social Network Index and the UCLA Loneliness Scale. Using descriptive statistics, we characterize the study

population. Correlations were run to assess associations between social isolation, loneliness, and psychoactive substance use.

Results: Our study sample included 89 adults (mean age of 61.4 years, SD 4.64), with 60% identifying as male, 33% as Hispanic, 9.5% as Lesbian, Gay, or Bisexual, and 22.7% currently unhoused. For the past 30-day substance use, 46.4% reported methamphetamine use and 39.3% reported fentanyl use. Nearly half the sample received care in an ED, and their mean PHQ-9 score was 10.0 (moderate depressive symptoms). In terms of social isolation, more isolation was associated with more psychoactive substance use ($r = -.251, p = .021, 95\% \text{BCa CI} = [-.398, -.080]$). Loneliness was likewise related to substance use such that greater feelings of loneliness were related to more psychoactive substance use, even after adjusting for depressive symptoms ($r = .210, p = .058, 95\% \text{BCa CI} = [.049, .361]$). As an additional check on whether social isolation or loneliness might be most related to substance use, the association between loneliness and substance use held when additionally adjusting for the size of the social network ($r = .293, p = .007, 95\% \text{BCa CI} = [.105, .485]$).

Conclusion: Among older adults with OUD, more social isolation and greater feelings of loneliness were associated with more psychoactive substance use. These results will inform the development of targeted strategies to improve social connectedness and health outcomes for older adults with OUD.

C95 Student Presentation, Encore Presentation

Data Visualization of Coastal Environmental Aging Research

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Coastal environments shape aging-related health and well-being, yet the geographic distribution of existing research remains uneven and poorly understood. This study demonstrates how data visualization can be applied within a scoping review to identify where research on coastal environmental conditions and aging has been conducted and where evidence gaps persist.

A comprehensive scoping review was performed across MEDLINE/PubMed, Web of Science, CINAHL Ultimate, PsycINFO, Scopus, GreenFILE, and the SOPHIE database, with searches completed between September 15 and November 15, 2025. Citations were imported into Covidence for deduplication, screening, and data extraction. Studies were eligible if they examined aging-related outcomes, cognitive change, caregiving, or military-connected populations in coastal or ecologically dynamic settings. Two reviewers independently screened citations and extracted geographic data. Study locations were visualized to map research coverage and identify under-represented regions.

The search yielded 46 included studies. Mapping showed that the United States accounted for the largest share ($n = 25$), including one study from Puerto Rico, with concentrations in Florida ($n = 6$), Louisiana ($n = 4$), Texas ($n = 5$), and other Atlantic and Gulf Coast states. The United Kingdom contributed seven studies, with four specifically referencing England. Western Europe was represented by Belgium, France, Spain, Sweden, and Norway ($n = 1$ each). Asia-Pacific locations included Australia ($n = 2$), China ($n = 1$), Japan ($n = 2$), India ($n = 1$), Bangladesh ($n = 1$), the Philippines ($n = 1$), and Indonesia ($n = 1$). Only one study originated from coastal Africa, conducted along the Kenyan coast. Visualization highlighted extensive geographic clustering in the United States and parts of Europe, with limited representation across the Caribbean, Pacific Islands, South Asia, and the African coastline.

Applying data visualization to scoping review methods clarifies where coastal aging research is concentrated and identifies regions with critical evidence gaps. This approach can support more geographically responsive research agendas addressing aging-related health in environmentally vulnerable coastal communities.

C96 Student Presentation

Longitudinal Associations of Race/Ethnicity and Caregiver Burden with Health Outcomes in Dementia Caregiving: Mediating Roles of Participation in Valued Activities and Caregiver Support

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Background: Family caregivers of persons living with dementia (PLWD) are at risk for adverse health outcomes. While participation in valued activities and caregiver support are key coping resources, their roles in explaining associations between race/ethnicity, caregiver burden, and health outcomes are not well understood. This study examined whether these coping resources partially account for these associations over two years.

Methods: Guided by the revised Sociocultural Stress and Coping Model, this longitudinal study used data from Rounds 5 (2015) and 7 (2017) of the National Health and Aging Trends Study linked to the National Study of Caregiving. The sample included 550 family caregivers of community-dwelling PLWD. Outcomes measured in 2017 were anxiety, depressive symptoms, psychological distress, and self-rated health. Independent variables measured in 2015 included race/ethnicity and caregiver burden (financial, emotional, physical, and overall). Mediators measured in 2015 included participation in valued activities (visiting friends/family, attending religious services, engaging in clubs/groups, and going out for enjoyment) and caregiver support (family/unpaid support, supportive services, and overall support). Survey-weighted path analyses with two simultaneous mediators were conducted using structural equation modeling in Stata 19.5.

Results: In 2015, caregivers had a mean age of 59.9 years (SE=0.8), 67.3% were female, and 52.1% were adult children; 51.8% were non-Hispanic White, 21.6% non-Hispanic Black, and 26.6% others. 47.5% co-resided with the PLWD, and 94.9% provided care for ≥ 1 year. Path analyses showed a significant effect of physical burden on depressive symptoms, driven by a unique significant indirect pathway through participation in valued activities, accounting for 37.3–40.6% of the total effect. Higher physical burden predicted lower activity participation, which in turn predicted greater depressive symptoms. No other support mediators were significant.

Conclusions: Participation in valued activities was identified as the pathway linking physical burden to depressive symptoms. These findings highlight the importance of identifying caregivers with high physical burden and supporting them in maintaining meaningful activity engagement through targeted interventions and policies.

C97 Student Presentation

Resource needs, burden, and distress among dementia caregivers

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Background

Caregivers for people with dementia have higher rates of unmet resource needs than other caregivers. Resource needs may be a modifiable contributor to distress and burden – common precursors for “caregiver burnout.” We examined the relationship between unmet resource needs and burden and distress among dementia caregivers.

Methods

This was a cross-sectional analysis of baseline data obtained from a randomized controlled trial evaluating CommunityRx-Dementia, a resource referral intervention for urban-dwelling dementia caregivers (N=343). Need for 14 social and caregiving resources was queried (e.g. free food, respite). Distress and burden were assessed using the 12-item Neuropsychiatric Inventory Questionnaire (range: 0-60) and Zarit Caregiver Burden Assessment (range: 0-48). Unadjusted and adjusted linear regression models were fit with burden and distress

by 1) resource need count and 2) resource need type. Analyses were adjusted for caregiver age, race, gender, education, income and care recipient dementia stage (mild or moderate/severe).

Results

Caregivers were largely Black (81%), women (78%), caring for more than 5 years (49%) and college-educated (55%). Mean burden and distress at baseline were moderate: 12.4 (sd=9.3) and 9.5 (sd=9.1). In adjusted analyses, number of baseline resource needs was significantly associated with higher baseline burden ($\beta=0.9$, 95% CI 0.6, 1.2) and distress ($\beta=0.9$, 95% CI 0.6, 1.2). Examining individual resource needs, a mental health need was most associated with burden ($\beta=6.1$ 95% CI 4.2, 8.1) and transportation need with distress ($\beta=4.7$, 95% CI 2.5, 6.9).

Conclusions

Resource needs, particularly modifiable needs such as transportation, home care, and mental health, were associated with clinically and statistically greater caregiver burden and distress at baseline. Future studies should examine the effect of resolving individual resource needs on burden and distress.

Need	Burden (β (95% CI))	Distress (β (95% CI))
Mental Health	6.1 (4.2, 8.1)	4.6 (2.5, 6.6)
Transportation	3.2 (1.0, 5.5)	4.7 (2.5, 6.9)
Home Care	4.9 (2.9, 6.9)	4.3 (2.2, 6.3)
Respite	4.5 (2.5, 6.5)	3.1 (1.1, 5.2)
Financial	4.4 (2.3, 6.6)	3.9 (1.7, 6.1)
Caregiver Education	3.2 (1.1, 5.2)	3.0 (0.9, 5.1)
End of Life Support	2.6 (0.2, 5.0)	3.1 (0.7, 5.5)
Legal	2.3 (0.1, 4.5)	2.6 (0.4, 4.8)
Food Delivery	2.2 (0.1, 4.3)	4.1 (2.0, 6.2)

C98 Student Presentation

Perceptions and Use of Fall Detection Devices:

A Qualitative Study

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Background: Falls are a leading cause of morbidity and mortality among older adults in the United States. Fall detection technologies enable timely response after a fall, though sustained use of these devices remains low. Barriers to use include stigma, discomfort, cost, false alarms, privacy concerns, and lack of integration into daily routines. Previous studies have been quantitative while few have conducted qualitative interviews. This study addresses this gap by interviewing older adults to capture their lived experiences. Findings will inform the future design and implementation of fall-detection devices to improve safety and independence for older adults.

Methods: We conducted a qualitative study with semistructured, individual interviews where audio was recorded and transcribed after obtaining informed consent. We interviewed 9 participants from an assisted living facility with an average age of 80.6, as well as 4 managers from the same living facility. Questions were related to: living arrangements, fall history, fall risk as well as awareness, use, and satisfaction with fall detection devices, perceptions of fall detection devices, experiences with use, and expectations for future use. Data was analyzed applying thematic analysis.

Results: Among those who chose to not use a fall detection device, they were not familiar with fall detection devices and found the technology challenging to use. Participants shared stories of friends who used a fall detection device that called an ambulance hours away rather than locally. Participants noted that there were many devices on the market at varying price points. Knowing which device to purchase was difficult and time consuming, often resulting in them not purchasing any device at all. Overall, participants expected devices to be more user friendly, lightweight and have some way to verify that the ambulance that was being called to pick them up was local and would respond within a timely fashion.

Conclusions: This data identifies common reasons for not utilizing various fall detection devices, even in those with a past history of falls. These findings will help develop future devices, and inform how clinicians talk to their patients about device implementation. This study establishes the context necessary for future research into how to quicken responses to falls in older populations.

C99 Student Presentation

Geriatric Patient Needs Assessment at Federally Qualified Health Center

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There are significant care gaps and opportunities in primary care for underserved English as Second Language (ESL) and monolingual older adults. It is essential to understand the perspectives and social and medical gaps within this population to build programs that align with patient-centered care. We conducted a qualitative study to understand the needs of older adult patients and the staff at a large federally qualified health center, Asian Health Services (AHS), to build an integrated geriatric care model at AHS.

We administered the Health Leads Social Needs Screening questionnaire and conducted in-depth interviews for 14 older adult patients in English and Cantonese. Participants were recruited from Patient Leadership Councils (10), Asian Network Pacific Home Care and Hospice programs (3), and through PCP visit shadowing (1). All interviews were audio-recorded and transcribed. We also shadowed and interviewed 12 staff members and documented their clinical and administrative workflows and gaps in those workflows. The staff interviewed include: 4 Primary Care Providers (PCP), Referrals Manager, Membership Services Manager, 3 Clinic Site Managers, a Physician Assistant, a Hospice Home Nurse, and the Chronic Care Management Program Nurse.

Of our 14 patient interviewees, 11 spoke only Cantonese and 3 spoke both Tagalog and English. 8 lived adjacent to Oakland Chinatown, while 6 lived in San Leandro or Alameda. From interviews and shadowing sessions, these themes emerged: 1) patients' timely access to quality care is greatly limited by transportation barriers, 2) scheduling visits with specialists is burdensome for patients due to language barriers, an unwillingness to pick up calls, and specialist offices being far away, 3) patients wish for longer and timelier visits with their PCP, and 4) patients do not feel empowered to improve their quality of life due to limited understanding of their medication regimen, health insurance benefits, technology, and financial support resources.

In the future, AHS should track referrals more closely to identify failed completion patterns. Additionally, AHS should also pinpoint underlying causes of high variability in PCP visit lengths and patient-provider communication gaps beyond language barriers. Validating our qualitative findings will equip AHS in building patient-centered workflows tailored to the needs, challenges, preferences of the senior patient population.

C100 Student Presentation

Perspectives on Healthy Aging among World Trade Center Responders

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Background:

World Trade Center (WTC) responders exposed to physical and psychological hazards during 9/11 rescue and recovery efforts face elevated risks of chronic illness, frailty, cognitive impairment, and polypharmacy. Promoting healthy aging in this population requires

understanding responders' priorities and incorporating them into care; yet little is known about their perspectives on aging, including the influence of WTC exposures on their understandings.

Methods:

We used purposive sampling to recruit WTC responders ≥ 50 years from two WTC Health Program clinics with variation in race, sex, age, and occupation (grouped as: protective services, trades, volunteers/others). We conducted semi-structured interviews between January and August 2025 using a topic guide that explored responders' ideas about healthy aging and the impact of WTC exposures on health. Using rapid qualitative analysis, we summarized each interview into a structured template and synthesized templates into a summary matrix to develop themes.

Results:

Participants (n=30; 15 from Mount Sinai and 15 from Rutgers) ranged in age from 51-84 years and represented diverse racial (White 67%, Black 20%, Asian 10%, other 3%) and occupational groups (protective services 37%, trades 33%, volunteers/other 30%); 33% were women. Responders interpreted aging through their WTC exposure history, describing uncertainty about whether health changes reflected aging, exposure, or both, with subthemes of health vigilance and perceived accelerated aging. Exposure-related uncertainty also shaped how responders approached healthy aging, which they described as an active, multidimensional process requiring proactive efforts across physical, cognitive, emotional, social, and spiritual domains. Many noted that several challenges, including their accumulated health conditions, made this work increasingly difficult.

Conclusion:

These findings highlight the ongoing tension between proactive efforts to age well, and the uncertainty shaped by 9/11-related exposures. Identifying responders' perspectives is critical for shaping aging-related conversations in the WTC Health Program, enabling providers to align care with responders' priorities and lived experiences as this population grows older.

C101 Student Presentation

Navigating PPE: Hospice Workers' Experiences Providing Care During the COVID-19 Pandemic

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Background: Personal protective equipment (PPE) was essential to protecting healthcare workers during the COVID-19 pandemic, yet its unique impact on the hospice setting remains understudied. Due to the unique demographic hospice treats, PPE usage may be accompanied by a variety of challenges. This study aims to elucidate how PPE shaped the clinical and interpersonal experiences of hospice workers during the COVID-19 pandemic.

Methods: Between April 2023 and January 2024, semi-structured interviews were conducted with staff from a hospice organization based in Tennessee. Participants encompassed physicians, nurses, certified nursing assistants, social workers, chaplains, community educators, administrators, and volunteers. Interview data was transcribed, coded, and analyzed through inductive thematic analysis.

Results: Four core themes emerged during analysis. First, major barriers to communication were present. Masks muffled speech, obscured lip movement, and concealed facial expressions, leading to frequent misunderstandings. Workers described needing to shout, repeat information, write messages, and use gestures to be understood, while others adopted transparent masks. Second, physical discomfort presented a significant challenge to healthcare delivery. Workers described PPE as smothering, cumbersome, and intensely hot, leading to irritation, dehydration, and reduced tolerance for prolonged visits. Several reported shortening visits or stepping outdoors to cool down.

Third, PPE shortages were present early in the pandemic, leading to reuse of masks, difficulty obtaining N95s, and inability to provide gloves to families. These shortages often lead to fear, hopelessness, and embarrassment. Fourth, the ability to establish rapport was compromised, particularly with patients suffering from dementia who were often fearful and confused, in addition to disagreements with family members on PPE.

Conclusions: While important for safety, PPE usage included substantial challenges to the hospice workforce. Taking into account the unique patients hospice workers treat, challenges with PPE were particularly noticeable while caring for an elderly demographic with sensory and cognitive impairment. Findings underscore the need for novel strategies that can balance both safety and the delivery of hospice care amidst ongoing public health emergencies.

C102 Student Presentation

Integration of the Age-Friendly Health Systems 4Ms Model: A View Through Oslerian Medicine

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Background: The principles of Oslerian medicine, inspired by Sir William Osler, emphasize holistic, person-centered care. While Osler's teachings originated over a century ago, his philosophy can be applied to many aspects of modern-day medicine, including geriatric care and the creation of age-friendly healthcare infrastructure. The 4Ms framework by the Institute for Healthcare Improvement provides one approach to geriatric care delivery through its four themes: What Matters, Medication, Mentation, and Mobility. This review examines how current implementation of the 4Ms framework reflects Osler's principles, with an emphasis on equity in caring for older adults.

Methods: A scoping review was conducted using articles identified through PubMed. Articles were included based on their relevance to the 4Ms framework, clinician perspectives, age-friendly care models, and health equity focus. Data extracted from the reviewed articles included survey responses, sample demographics, care settings, and equity outcomes.

Results: While discussions surrounding the different 4Ms tend to be initiated by providers, challenges lay in the operationalization of these conversations into tangible care plans. Prioritization among the 4Ms also tended to vary by profession; while physicians primarily focused on the "What Matters" domain, interdisciplinary care team members helped promote other domains. Notably, disparities in access to 4Ms-related discussions were seen among older adult populations along the basis of language and socioeconomic status.

Conclusion: The data suggests that, despite their value, the 4Ms are inconsistently integrated into existing health systems. Future efforts should prioritize standardized workflow integration and inter-professional collaboration to ensure consistent delivery of all 4Ms. Additionally, language-inclusive outreach and use of accessible technology are essential to reduce healthcare inequities. Strengthening these structural support mechanisms may help transform the 4Ms from an aspirational healthcare model to an institutional standard of age-friendly care closely aligned with the tenets of Oslerian medicine.

C103 Student Presentation

Volunteering in Health Care as a Long-Term Commitment and Lifestyle in Older Age

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Background: Common problems that older adults face is social isolation, cognitive decline, and loss of purpose. Previous research has found that volunteering can improve psychosocial wellbeing and reduce mortality risk in older adults by providing social connection, physical engagement, and new life meaning.

Methods: We examined the benefits of long-term volunteering on psychosocial challenges in older adults and their potential to be incorporated into a healthy aging plan. A cross-sectional anonymous survey evaluated the motivations and attitudes of volunteers within a hospital-based volunteer program. We analyzed information from surveys of volunteers aged 65 years and older, with 3 or more years of volunteer experience (N=30). We used descriptive statistics, including means and standard deviations for continuous variables, and frequencies and percentages for categorical variables. All statistical analyses were conducted with R.

Results: Volunteers had an average age of 75.3 years (range=65-85), reflecting a cohort of older volunteers. A majority of respondents identified as Japanese (90%) and female (90%) with 20% volunteering between 3-5 years and 80% volunteering 6+ years, indicating a record of long-term volunteering. A majority (73%) indicated volunteering for >12 hours per month (73%), suggesting a habitual record. The top 5 motivators were: personal satisfaction/sense of purpose (93%), desire to help others (90%), make a positive impact in their community (73%), meet new people (73%), and influence positive change (47%); reflecting healthy lifestyle principles through volunteerism. The top 3 personal benefits for respondents were: building personal relationships (93%), improving mental or physical health (87%), and feeling good about themselves (80%); demonstrating principles of healthy aging.

Conclusions: Long-term volunteering reflects principles of both healthy living and healthy aging. These results imply that long-term volunteering can be reconceptualized as a component of a healthy lifestyle among aging adults. Clinicians can recommend long-term volunteerism as part of a sustainable lifestyle strategy to support healthy aging and psychosocial wellbeing.

C104 Student Presentation

Interdisciplinary Opportunities for Dementia Care

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Background

Care for Alzheimer's Disease and Related Dementias (ADRD) is rapidly changing. New therapeutics depend on early identification by primary care providers (PCPs). To identify barriers to evolving ADRD management practices, PCP perspectives were explored.

Methods

Nine PCPs were interviewed with a semi-structured interview guide, elucidating practices across six ADRD care steps. Transcribed interviews were coded in NVivo in MacGuire and Delahunt's thematic analysis method. Two independent reviewers had good inter-coder reliability (Cohen's kappa = 0.70). A matrix analysis identified barriers and opportunities at each care step.

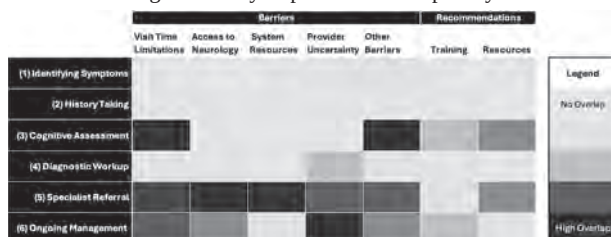
Results

Of the 30 points of intersection between care steps and barriers, 12 had no challenges identified, principally in clinical history and symptom identification. Barriers were frequent in cognitive assessment, specialist referral and ongoing management. Barriers to cognitive assessment included visit time limitations and test interpretability.

related to primary language and literacy. PCPs recognized a need for assessment tools adaptable to the primary care setting. Due to PCP uncertainty of response to common age-related findings, providers were hesitant to order imaging. New AD/BD image and fluid biomarker-based diagnostics were not part of PCP workflows. Long wait times created barriers to neurology referral. PCPs recommended triaged referral pathways or message-based support for improved interdisciplinary collaboration. Provider uncertainty regarding initiation of established dementia medications created management barriers; suggestions included trainings and clinical decision support tools.

Conclusions

In this busy urban practice, future state dementia management will build on existing PCP strengths in symptom identification and history taking. Adapted cognitive assessment tools and new trainings to address targeted areas of PCP diagnostic uncertainty may improve early identification. Escalation pathways and neurology-supported medication management may improve interdisciplinary collaboration.



C105 Student Presentation

Surrogate Decision Makers' Perspectives on Facilitators of Goal-Concordant Care for Patients with Dementia During Emergency Medical Response

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Background: Many people with dementia prioritize comfort-focused care, which may not align with default interventions implemented during emergency medical services (EMS) response. Little is known about barriers and facilitators to achieving goal-concordant care during EMS response.

Methods: We conducted semi-structured qualitative interviews with healthcare surrogate decision makers (SDMs) for older adults (age ≥ 65 years) with dementia transported to the Emergency Department by ambulance. SDMs were identified between March and June 2025 through the hospital electronic health records at two academic medical centers in the West coast. Interviews were audio recorded, transcribed, and thematically analyzed through a combined inductive and deductive approach.

Results: The median age of SDMs (n=8) was 65 years and the median age of the corresponding patients was 87 years. Most (n=6) patients did not reside with their SDM. SDMs described facilitators of goal concordant care during EMS response (Table 1) including: (1) having the opportunity to talk directly with EMS; (2) involving the patient in real-time medical decisions as able, even in the setting of severe cognitive; (3) having advance care planning documents which made communication more efficient and served as a guide even when real-world context differed.

Conclusions: SDMs described that having direct communication with EMS, engaging the patient as much as possible while acknowledging cognitive deficits, and referring to advanced care planning documents as guides even when faced with contextually nuanced decisions facilitated goal-concordant care during medical emergencies.

Facilitators of Goal-Concordant Care for Patients with Dementia During Emergency Medical Services (EMS) Response from the Perspectives of their Surrogate Decision-Makers

Facilitator	Representative Text Example
Direct communication between surrogate decision-maker and EMS	"I think that if I had talked to the EMT and really explained the situation with regard to M, her wishes and all, I think that we would have been able to handle the emergency at her residence. And she would not have been transferred to the hospital."
Patient involvement in care decisions as able	"I still make sure I talk to [J] and take the time to explain what they're talking about, and he still is having the ability to sort of maybe after two or three explanations to Say oh, yeah, I want that. But I think carefully without prodding about sort of getting, bringing him in on the discussions and making some part of the decision."
Advanced care planning documents may serve as a guide	"If they, if they know that there is such a thing [referring to POLST], they can be guided by that. And they may forget what's on it, but if they keep it as a safe place, and they're called. They can pull that out, and they can look at it, and it can help them to know what to be able to say to the EMTs"

C106 Student Presentation

Care-Limiting Advance Directives Among Hospitalized Centenarians

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Background: Advance directives (ADs) impact end-of-life decisions and often change following a change in health status yet there has been little research done on changes to ADs over time. The US Census Bureau estimates that by 2054, the US population of centenarians will quadruple to 422,000. However, limited research exists on ADs among centenarians despite their advanced age and greater likelihood of chronic illness.

Research Questions: What are the rates of care-limiting advance directives (CLADs) at the time of hospital admission and discharge among centenarians? Among centenarian admissions, what proportion had a change in AD status during hospitalization? Of the centenarians with a CLAD, what proportion were female versus male?

Methods: This is a retrospective, secondary analysis of a quality improvement database of admissions of 400-bed community teaching hospital from 2017 to 2020. A CLAD is defined as a Do Not Resuscitate order or a Do Not Intubate order. Admissions who had no reports on ADs in the medical record or expired in the hospital were excluded. Statistical analysis to compare groups was conducted using Chi-square test with a two-sided p-value <0.05 for statistical significance.

Results: Among 582 admissions aged 100+, 260 were excluded due to expiration or missing data. Of the 322 eligible admissions, approximately 1/4 (22.7%) had a CLAD at admission. However, at discharge nearly 1/2 (46.3%) had a CLAD. Among the 322 eligible admissions, 76 (23.6%) had a change in AD status during hospitalization while 246 (76.4%) had no change. Among centenarian admissions with a CLAD on admission, none changed at discharge. Among those with no CLAD on admission, 1/3 changed to a CLAD at discharge (0% vs 30.5%) (*p=<0.001). There is no significant association between sex and CLADs (p=0.173).

Conclusions: The prevalence of CLADs among hospitalized centenarians was low. A significantly higher proportion of admissions changed to a CLAD than changed to no CLAD during hospitalization. There was no association between female sex and CLADs during hospitalization. Limitations include that a substantial proportion of the centenarian population did not have ADs and the use of admissions rather than individual patients. Further research should investigate rates of CLADs among the general, non-hospitalized centenarian population and evaluate reasons for AD non-completion, admission to the hospital, and AD status change.

C107 Student Presentation

Exploring Urinary Incontinence Management in Nursing Homes: Barriers and Facilitators to Best-Practice Care

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Background: Urinary incontinence (UI) affects up to 70% of nursing home (NH) residents and can be challenging to manage in resource-limited settings. Little is known about real-world practices of UI care in NHs. The goal of this study was to elucidate current management strategies of UI in NHs and identify potential areas for improvement.

Methods: We conducted semi-structured interviews with NH providers in Virginia. Interviews explored three areas: (1) UI diagnostic approaches, (2) UI management strategies, and (3) factors influencing best-practice UI care. Each transcript was content coded by two reviewers using a rapid coding approach.

Results: We interviewed eleven NH providers [4 medical directors, 3 MDs, and 4 advanced practice providers (APPs)] who had an average of 15.1 (SD=10.4) years in practice. Most providers (63.6%, n=7) worked at a for-profit NH in a suburban or urban area (90.9%, n=10). Providers viewed UI as a multifactorial issue that required a detailed evaluation of patient history, medications, and function. Management strategies included timed voids, pelvic floor strengthening, treatment of comorbidities, and medication management, including deprescribing. Providers used patient-specific approaches to treatment, accounting for quality of life and patient comorbidities, and rarely prescribed medications for urinary incontinence or referred patients for specialty care. The most notable barriers to best-practice UI care were limited provider knowledge, staffing shortages, staff perspectives on the importance and/or burden of incontinence care and toileting, patient resistance to changing overactive bladder medications, and medication costs.

Conclusions: UI care in NHs focuses primarily on conservative management. We identified areas for improvement in UI care including increasing provider knowledge of UI therapeutics, patient counseling on UI treatment, and improving staff attitudes towards toileting. Results from this study will inform future interventions to enhance UI management in NH patients.

C108 Student Presentation

A Socioecological Approach to Resilience During the HIV and COVID-19 Pandemics

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Background

Older adults were disproportionately affected during the COVID-19 pandemic, experiencing the highest levels of morbidity and mortality. For HIV long term survivors, who survived the early years of the ongoing HIV/AIDS pandemic, COVID-19 was not the first pandemic they survived. We sought to examine this population's "pandemic expertise" to understand factors that contributed to their resilience during the HIV pandemic with the goal of informing strategies for other older adults during future health emergencies.

Methods

One on one in depth qualitative interviews in English and Spanish were conducted with 14 older adults with HIV. We coded for themes identifying similarities and differences between the HIV and COVID-19 pandemics and used a social ecological framework (individual, interpersonal, community, and structural levels) to analyze factors that promoted resilience during the early days of the HIV pandemic.

Results

Participants cited trust in healthcare professionals and initial lack of knowledge about disease transmission as similarities between the HIV and COVID-19 pandemics while transmission and speed of vaccine development were noted differences. Applying the social ecological framework, the most common themes at the individual level were adaptability, purpose, and quality of life. Interviewees stated that having a purpose and reason to live for the next day improves their quality of life and contributes to their resilience. On an interpersonal level, social support was a recurring theme and within the community level, stigma and support groups were highlighted. Experiencing stigma was described as initially hindering resilience by depriving interviewees of social support. However, many stated that overcoming stigma and finding purpose in combatting it ultimately contributed to their resilience. Lastly, on the structural level, trust in healthcare was reported as contributing to resilience due to having a trusted source on current data about virus pathology and transmission.

Conclusion

The interviews of these HIV long-term survivors demonstrated that surviving the early HIV pandemic fostered adaptability and purpose while highlighting the importance of social support and trust in healthcare for their resilience during COVID-19. Their insights provide information on ways to build resilience in older adults and improve their quality of life during future public health emergencies.

C109 Student Presentation

Strength on Wheels Improves Exercise Motivation in Homebound Older Adults

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Background: Homebound older adults are at high risk of developing frailty, which is characterized by a decline in multiple systems that increases vulnerability to adverse health outcomes. Nearly 70% of homebound older adults in the U.S. are frail, threatening their ability to remain in their own homes. While physical activity has been shown to improve frailty in older adults, exercise programs typically take place outside of the home and are inaccessible to this population.

Methods: In a parent randomized clinical trial, "Strength on Wheels", with 101 participants, half of the participants (treatment group) were given an exercise kit (2 tennis balls, 2 one-pound weights, 1 towel) and weekly exercise handouts with their Meals on Wheels meal delivery for 12 weeks. The control group only received meals, and all participants were given activity trackers to measure physical activity. To gain a better understanding of exercise motivations, participants were qualitatively surveyed through phone calls. This 20-question survey had 8 questions related to the assigned exercises and duration of physical activity for the treatment group, and both treatment and control groups answered 12 questions on exercise motivation and preferences.

Results: The average response rate was 26% and average age was 75 years. 17 (65%) were female, 13 (50%) were in the exercise group, and 8 (31%) were Spanish-speaking. In the exercise group, 88% of participants utilized the exercise kit and handouts, 50% exercised five or more times a week, and 75% reported that they continued exercising after the study concluded. Interestingly, 92% of participants in the control group agreed or strongly agreed that they enjoyed exercise, but only 69% of participants in the exercise group said the same. However, fewer exercise participants (23%) agreed or strongly agreed that it was difficult to incorporate exercises into their daily routine, while more control participants (38%) felt it was difficult.

Conclusions: Our results suggest that designing accessible exercise programs can enhance exercise motivation in frail, homebound older adults. While these older adults may experience barriers to exercise, many of them have a positive attitude regarding its benefits and importance to their well-being. Therefore, it is imperative to design exercise interventions that overcome location and language barriers for homebound older adults.

C110 Student Presentation, Encore Presentation
Voices from the community: perspectives on LGBTQIA+ affirming care for older adults

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Background:

Older LGBTQIA+ adults are numerous, diverse, and face disproportionate health disparities. There remains a gap in knowledge about LGBTQIA+ older adults' perceptions and experiences in affirming healthcare settings. In 2023, a first-in-the-nation primary care program for LGBTQIA+ older adults ages 55+ was established in an urban academic setting in the northeastern United States. An initial series of semi-structured interviews assessed the experiences of a subset of patients engaged in this program.

Methods:

A semi-structured interview was developed and refined based on literature review of health vulnerabilities of LGBTQIA+ older adults. The interview focused on past experiences with the healthcare system, patient input on what is most important in healthcare, and specific experiences in the LGBTQIA+ program. LGBTQIA+ individuals ages 55+ were recruited from the existing pool of patients in this program. Data were analyzed with a grounded theory approach.

Results:

This analysis included six cisgender gay men over the age of 55. Common themes in LGBTQIA+ healthcare arose, including the ongoing impact of the HIV/AIDS epidemic and the importance of close connection to LGBTQIA+ communities. Multiple participants noted they have not focused their past healthcare on their identities as gay men; some did not always disclose their sexual orientation. Experiences with the affirming LGBTQIA+ primary care program were universally praised, with participants citing the importance of community visibility and cultural humility training for the interprofessional team.

Conclusions:

This data demonstrate the importance of community connection, LGBTQIA+ visibility, and involvement of the interprofessional team in providing affirming, safe, inclusive healthcare for older cisgender gay men. The history of the AIDS crisis, with its discrimination and stigma, clearly continues to affect members of this population. Interestingly, many participants noted that sexual orientation has not been a focus of past healthcare; some did not even reveal their sexual orientation to prior providers. Despite this, all participants reported immense value in having their needs as cisgender gay men are understood, heard, and valued in a dedicated setting. Future interviews will attempt to capture more voices from other LGBTQIA+ communities.

C111 Student Presentation
Understanding the Mental Health Challenges and Stressors of Family Caregivers in Hospice Care

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Background: Family caregivers (CG) of home hospice patients often experience significant mental health challenges. Despite supportive services from hospice, 33% of hospice CGs experience moderate-to-severe anxiety, and 23% of hospice CGs experience moderate-to-severe depression. Understanding the mental health needs and stressors of hospice CGs is essential for developing interventions to improve their well-being. Our study's objective is to understand the mental health challenges and stressors of CGs receiving home hospice care.

Methods: We conducted semi-structured interviews with 26 caregivers who received care from a non-profit hospice organization. Interviews focused on understanding CG's mental health challenges and stressors during their hospice experience. Data were analyzed by two independent coders using qualitative analysis methods.

Results: Of the 26 CGs interviewed, the mean age of CGs was 58 years old; with a majority being female (n=20, 77%) and adult children (n=22, 85%). A majority of CGs described symptoms of anxiety and depression during their hospice experience. The most common contributing stressors associated with their mental health include (1) being overwhelmed with patient care responsibilities, (2) stress related to the unpredictability and unknowns of end-of-life care, and (3) emotional strain from witnessing a loved one's decline and death. Notably, 50% of CGs reported that they did not receive formal mental health services, and a majority (n=16, 62%) relied on social support to cope.

Conclusions: Overall, many CGs experienced significant mental health burden during their loved one's end-of-life care. Anxiety and depression were often associated with being overwhelmed with responsibilities, the unpredictability of hospice care, and the emotional impact of witnessing decline and death. These insights can help us tailor psychotherapy interventions to support the mental health of hospice caregivers.

C112 Student Presentation
Nursing home staff perceptions of using radio frequency sensors to detect respiratory distress in patients with advanced Alzheimer's Disease and related dementia

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Background: Respiratory distress, often caused by respiratory or cardiac illness, is common and under-detected among nursing home (NH) patients with advanced Alzheimer's Disease and Related Dementia (ADRD). Radio frequency (RF) sensors are a promising non-invasive technology that can wirelessly and continuously capture cardiopulmonary signals, helping to identify distress. However, it is not known how receptive NH staff are to potentially using this type of technology for the patients they care for. Our study's objective is to understand NH staff perceptions of using RF sensor technology.

Methods: We conducted semi-structured interviews with 26 NH staff at a single non-profit NH organization. Interviews focused on identifying potential benefits and challenges of using RF technology. Data were analyzed by two independent coders using qualitative analysis.

Results: Of the 26 NH staff interviewed, 4 were physicians, 11 were nurses, 10 were certified nurse assistants, and 1 was a clinical development liaison. After learning about RF sensors, participants shared that sensors could potentially be implemented as (1) a complementary tool to monitor heart rate and respiratory rate, (2) a way to improve recognition of subtle changes in patient conditions that might have been undetected, and (3) support in making informed clinical decisions. However, they also identified potential factors that need to be addressed before large scale implementation, which include (1) understanding the sensors' impact on patient safety, (2) the accuracy and reliability of the data collected, and (3) whether the sensor is waterproof. To address these concerns, NH staff emphasized the need for a durable RF sensor device and training protocols for staff.

Conclusions: Overall, NH staff responded favorably to the idea of implementing RF technology in their clinical care. After learning about the benefits of RF technology, many believed it could be a promising tool for monitoring patient status and helping make informed clinical decisions. These insights can help guide the implementation of RF technology for patient care.

C113 Student Presentation

Navigating Deprescribing in the Emergency Department: A Qualitative Exploration of Barriers and Facilitators Following Adverse Drug Events

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Background

Presentation to the emergency department (ED) for acetylsalicylic acid (ASA)-related hemorrhage presents an opportune moment to consider deprescribing (e.g., discontinuation of primary prevention ASA use). Little is known about the current standard of care in ASA management after a patient experiences hemorrhage. The objective of this study was to better understand the reasons why patients may or may not obtain counsel on deprescribing ASA following an ED encounter for bleeding.

Methods

We conducted and recorded semi-structured, one-on-one qualitative interviews with daily ASA users roughly a month after a hemorrhage-related ED visit from July 2025 – August 2025. Interview recordings were reviewed for facilitators and barriers for ASA deprescribing by at least two coders. After an independent review, coders met as a group to consolidate themes through human centered design methods using sticky notes on a virtual whiteboard. Common themes were reported using content and thematic analysis with a focus on facilitators and barriers to receipt of deprescribing counsel on ASA after an ED encounter for bleeding.

Results

We interviewed 20 participants who presented to the ED with hemorrhage while on ASA. We identified four key barriers to deprescribing, including: (1) favorable perception of medication, (2) fear of medication discontinuation, (3) requirement of prescriber involvement in deprescription decision-making, (4) broader culture of ‘it’s just ASA’ in the general population (i.e., assumption that ASA is relatively benign). Similarly, we identified two key facilitators to deprescribing, including: (1) experienced/perceived safety concerns and (2) education/awareness of deprescribing in the ED.

Conclusion

We found that many patients who experience hemorrhage while on ASA were open to deprescribing but wanted their prescribing physician to be involved in the process. An ED educational intervention on deprescribing may increase patients’ awareness of the benefits of discontinuing ASA and empower them to have informed conversations with their prescribers.

C114 Student Presentation

Melatonin as a Modulator of Osteoblast Function and Bone Formation in Aging Populations

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Introduction: Melatonin exerts strong osteogenic effects on bone formation by directly stimulating osteoblast differentiation, activity, and mineralization.

Methods: A systematic review was conducted following PRISMA guidelines. 4 databases (PubMed n=83, Cochrane Library n=48, Web of Science n=92, and Medline Ovide n=71) were searched for studies examining melatonin’s effects on bone cells and homeostasis, yielding 294 articles. 77 articles were removed due to duplication and 11 were removed due to not being in English. Articles were then screened by two independent reviewers, with inclusion criteria focusing on melatonin’s molecular mechanisms and its relationship to

osteoblasts, osteoclasts, and osteocytes. This eliminated 143 studies and yielded 63 studies for the systematic review.

Significance: Melatonin activates the MT2 receptor, which in turn upregulates RUNX2 and bone morphogenetic proteins (BMP-2 and BMP-4), while also increasing osteocalcin and osteopontin expression. These pathways promote mesenchymal stem cell differentiation to osteoblasts; it enhances the expression of osteocalcin and bone sialoprotein to accelerate mineralization from 21 days to 12 days. Melatonin also activates SIRT1 and AMPK pathways, which protect RUNX2 from degradation and enhance osteogenic gene transcription. Additionally, melatonin’s contains antioxidant effects that counteract oxidative stress that can impair osteoblast viability and function. Both in vivo and in vitro studies have shown that pharmacologic melatonin enhances osteoblast proliferation, matrix deposition, and mineralization in a dose-dependent manner; increasing bone density more than hormone replacement therapy. Together, these melatonin-derived benefits on bone suggest that melatonin supplementation during aging may provide a low-cost adjunct and aid in both post-menopausal (type I) as well as senile osteoporosis (type II).

C115 Student Presentation

Inflammation and Alpha-1A Adrenergic Receptors in Aging Cardiomyocytes

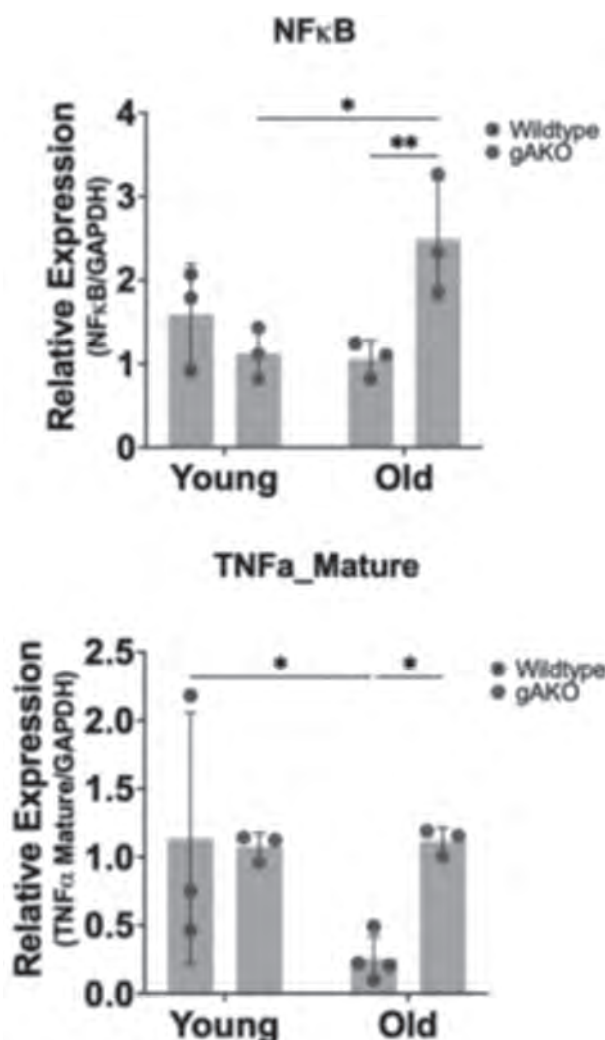
J. Frisbee, B. Alcira, B. Jensen. *UNC School of Medicine, Chapel Hill, NC*.

Background: Inflammaging encapsulates inflammatory processes that arise with aging and increase disease risk. It connects strongly to cardiology, a key contributor to both atherosclerosis and myeloid cell dysplasia. Another area of cardiovascular research is the protective function of alpha-1 adrenergic receptors in the heart. alpha-1A-KO mice have shorter survival, and aged alpha-1A-KO mice have evidence of contractile dysfunction. This adverse, age-related phenotype mechanism is unknown. Inflammaging and alpha-1 AR activation have limited research in conjunction with each other. This project aimed to test whether alpha-1A ARs modulated inflammation in the mouse heart.

Methods: Western blot analysis of pro-inflammatory markers, macrophage marker CD163, and the STAT pathway were performed on cardiac tissue of young and old mice, both wild types and alpha-1 AR genetic knockouts of each.

Results: NFkB and TNFα blots for older alpha-1A-KO mice had increased inflammatory markers. CD163 had no significant difference of protein levels across samples. F4/80 and STAT pathway blots revealed nonspecific binding throughout.

Conclusion: NFkB and TNFα blots align with prior research, showing greater inflammatory marker levels in older mice. The results of these blots also suggest a potential connection to expression of the Alpha-1A receptor, showing higher levels in gAKO mice. This points to inflammation modulation as a potential mechanism of alpha-1A ARs.



NFκB and TNFα western blot quantifications

C116 Student Presentation**Impact of a Peer-led Geriatrics 5M's Educational Workshop on Internal Medicine Residents**

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Background: As the U.S population ages, the demand for high-quality geriatric medical education continues to grow. There is a lack of trained geriatricians in the U.S. to meet this need, and Internal Medicine (IM) physicians can help fill this deficit (i). Integrating geriatric education into IM residency training is essential. Due to this deficit in geriatricians, utilizing residents and fellows in geriatric training initiatives can improve access to geriatric education. The aim of this study is to examine whether a resident and fellow-led workshop on Geriatrics 5Ms was acceptable to IM residents and perceived as comparable to an attending-led format.

Methods: The workshop was adapted from Schwartz's "Geriatrics 5Ms for Primary Care Workshop" (2019), with permission (ii). 48 residents (PGY1-3) from Florida Atlantic University's Internal Medicine Residency Program participated in the workshop and were asked to complete a post-workshop survey. The following questions were analyzed for this abstract: 1) "Did you like the peer-led learning experience (sessions led by residents/fellows, instead of faculty attendings)?" 2) "In your opinion, a workshop led by attendings/faculty would be better?" Both with answer choices of yes, no, and neutral.

Results: For the first question, 46/48 (96%) residents reported that they liked the peer-led learning experience; 2/48 (4%) were neutral. For the second question, 17/48 (35%) residents reported that they did not think that a workshop led by attendings would be better; 28/28 (58%) were neutral. 2/48 (4%) reported that they did think attendings would be better leads for the workshop and 1/48 (2%) reported that a combination would be their preference.

Conclusion: IM residents participating in this geriatric 5M's workshop largely liked or were neutral about the peer-led nature of the geriatric education that they received. These findings suggest that resident-led geriatric education may be a feasible and acceptable approach in the future, given the scarcity of geriatricians available to teach core geriatric competencies to IM residents.

i Rentsch S, Vitale CA, Zietlow K. Prioritizing geriatrics in medical education improves care for all. *Med Educ Online*. 2022;27(1):2105549.

ii Phillips SC, Hawley CE, Triantafylidis LK, Schwartz AW. Geriatrics 5Ms for Primary Care Workshop. *MedEdPORTAL*. 2019;15:10814. Published 2019 Mar 15.

C117 Student Presentation**Implementation of a Pre-health Student Dementia Support Program to Improve Caregiver Patient Ratios and Expand Low Cost Memory Care Services**

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1. *Texas Tech University Health Sciences Center, Lubbock, Lubbock, TX*; 2. *Texas Tech University, Lubbock, TX*.

Unpaid family and community caregivers delivered an estimated 18.4 billion hours of care to individuals with dementia in 2017. Even with this enormous unpaid contribution, the projected lifetime expense for one person with dementia, including medical care, long term housing, and skilled services, remains near 341,840 dollars. In an effort to ease the financial burden of additional staffing, we developed a prehealth student volunteering and mentorship program based in a skilled nursing home memory unit. Friendly Fridays began in 2016 and continues today through current Texas Tech University student officers. The current leadership focuses on sustaining the mission while expanding participation and structured peer mentorship for new volunteers, with recent growth in pre-nursing student involvement and increased emphasis on interprofessional education through collaborative service experiences alongside facility staff. The program places university students on weekly visits where they provide supportive services such as companionship, emotional reassurance, help with feeding, and engagement in structured activities. Students also design and run specific projects including a wheelchair based exercise program, therapy animal visits, and music sessions that draw on evidence for nonpharmacologic management of dementia symptoms. We monitored the initiative by recording attendance through an online sign in system and photographs, logging the time devoted to patient contact, and documenting outcomes from each student-led project along with extra hours spent on planning and leadership. Participants gained clinical volunteer experience, project management skills, and mentorship that could strengthen their medical or nursing school applications. The sustainability of the program rests on a mutually beneficial relationship among prehealth students, members of the American Geriatrics Society Student Interest Group, nursing home staff, and residents with dementia. Because memory care patients require intensive supportive contact while prehealth students seek meaningful exposure to geriatric care, organizing this student workforce offers a practical way to expand high quality dementia support while avoiding additional financial strain on patients, caregivers, or the health care system.

C118 Student Presentation

Optimizing healthy aging: A preventative approach to support community-dwelling older adults

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Many individuals remain unaware of hidden health conditions they may be living with, alongside limited knowledge or resources to proactively support wellbeing. Older adults face multifaceted challenges to aging well, with intrinsic capacity decline emerging as a critical and often under-recognized concern linked to disability, frailty, hospitalization, and mortality (WHO, 2017; Zhao et al., 2024). Research supports proactive, multidimensional strategies to detect and prevent age-related decline, including brief geriatric assessments (Seematter-Bagnoud & Büla, 2018), cognitive and strength screening (Adama et al., 2020; McGrath et al., 2024), and environmental modifications that promote safe aging in place (Stark et al., 2021; Washington et al., 2025). Despite strong evidence that intrinsic capacity decline predicts adverse outcomes, healthcare systems often fail to identify early signs due to training gaps, fragmented care models, and limited integration of prevention-focused frameworks (Owusu-Addo, 2021; WHO, 2017). This approach will target multiple areas of occupation, including health management, IADLs, and sleep, recognizing their interdependence within a holistic, community-based OT perspective. A literature review will analyze the occupational and health needs of community-dwelling older adults. The Person-Environment-Occupation (PEO) model will guide the project due to its focus on the dynamic interactions among individuals, environments, and occupations (Law, 1996). The anticipated product is a healthy-aging program for community-dwelling adults that includes assessment and education components practitioners can use for prevention and health promotion. This program aims to enhance awareness for individuals and caregivers, support occupational performance, reduce hospitalization risk, improve quality of life, and promote aging in place.

C119 Student Presentation

Assessing Physician's Understanding, Awareness, and Screening Practices for Hearing Loss in Older Adults

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Background: Age related hearing loss (ARHL) is a type of sensorineural hearing loss that affects most older adults, impacting physical and mental health. Prompt diagnosis is key to reducing the burden on affected patients, and screening can be done in the primary care setting. This study sought to characterize Family Physicians' screening practices, identify key barriers, and investigate potential modifiers of screening frequency.

Methods: A survey was designed and electronically distributed to 106 faculty physicians and residents in the UNC Family Medicine department. 38 physicians completed the survey. Descriptive statistics were done for all variables. Experience, screening competency, treatment knowledge, and comfort with hearing loss-related discussion (HLRD) were analyzed using linear regression, with screening frequency as the dependent variable. The same variables (except experience) were analyzed using multiple regression analysis with experience as a control.

Results: 23.7% of respondents reported screening "most" or "all or almost all" patients regularly for ARHL. The most prevalent barrier was lack of time (81.6% selected), with lack of confidence in assessment skills as the second most prevalent barrier (39.5% selected). All linear regressions were statistically significant and positive, with coefficients ranging from 0.05 (experience) and 0.70 (screening competency). Multiple regression analysis between perceived screening

competency and screening frequency was statistically significant when controlling for years of experience, with a coefficient of 0.5.

Conclusions: Screening for ARHL was relatively low and key barriers were a lack of time and a lack of confidence in skills. Time is a largely non-modifiable barrier, but confidence in assessment skills is an area for improvement to increase screening frequency. This can be achieved through education sessions and physician training. The positive associations between perceived screening competency and screening frequency also support idea. Providing targeted training for physicians in these areas can improve early identification of ARHL in older adults and help them maintain their quality of life longer.

C120 Student Presentation

Virtual Dementia Caregiver Bootcamp: Empowering Caregivers Through Knowledge and Skills

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Background:

Caregivers of people living with dementia (PLWD) need support, education, and training. We developed a novel online format of lunch-time sessions to educate caregivers on multifaceted dementia and caregiving topics and then surveyed attendees to measure satisfaction, learning, and reproducible feasibility.

Methods:

We expanded on the UCLA Alzheimer's and Dementia Care Program's "Caregiver Bootcamp" curriculum with permission, adapting it to fit an online-session format and incorporating new speakers and caregiving topics. Within a geriatric primary care clinic in an academic medical center, we invited the family caregivers of PLWD to participate. The sessions were led by experienced licensed geriatric social workers with guest speakers, including physical therapists, nurse practitioners, and physicians. We conducted 4 weeks of twice-weekly 1-hour lunch-time sessions, held over Zoom. Participants completed surveys about caregiver relationships and bootcamp learnings, including Likert-scale questions (0 being strongly disagree, and 10 being strongly agree) and free-text responses about growth in caregiver skills, knowledge, and overall ratings of the bootcamp.

Results:

Over the bootcamp series, 18–31 caregivers attended each of the 8 sessions. Overall, 36 caregivers completed a pre-survey and 23 completed the post-survey. 50% were a spouse/partner, and 45% identified as children of PLWD. In the post survey, caregivers rated "I feel like my ability to cope with the hardships of caregiving has increased thanks to this bootcamp" as 7.6/10, and "I feel like my confidence as a caregiver has increased thanks to this bootcamp" as 7.7/10. Caregivers strongly agreed that they would recommend the bootcamp (9.4/10) and that their time was well spent (9.1/10). In free text responses, participants reported greater patience, empathy, and self-compassion; improved communication techniques ("yes, and" improv, redirecting); and development of practical safety strategies and tools. They also reported feeling validated from connecting with other caregivers.

Conclusion:

Our dementia caregiver bootcamp increased caregivers' confidence and self-reported knowledge, and participants reported high levels of satisfaction and feeling less alone. This virtual format was convenient for caregivers, and can be replicated to have a broader impact on more caregivers of PLWD.

C121 Student Presentation

Deepening the Dementia Dialogue: Refining an Educational Workshop for Medical Students

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University of Texas Southwestern Medical Center, Dallas, TX.

Background:

Dementia prevalence continues to rise, yet substantial gaps in dementia education persist in undergraduate medical training. A third annual dementia workshop was held to increase pre-clinical medical students' exposure to person-centered dementia care. Topics included cognitive screening, caregiver support, communicating a dementia diagnosis, and differentiating dementia from delirium. This study evaluates the impact of the latest workshop iteration, refined based on prior feedback.

Methods:

The 90-minute voluntary workshop was facilitated by faculty and residents in psychiatry, neurology, and geriatric medicine, a licensed clinical social worker, and a newly added caregiver. Feedback highlighted the need for a caregiver's perspective, clearer distinction between mild cognitive impairment (MCI) and dementia, a simplified approach to dementia and delirium management focused on non-pharmacologic strategies, and improved flow. In response, this iteration incorporated a caregiver facilitator, added learning objectives on differentiating MCI and dementia and emphasizing non-pharmacologic management, and streamlined station transitions. Pre- and post-workshop surveys were matched anonymously and analyzed using paired t-tests and McNemar's tests.

Results:

The average Likert score increased significantly for students' comfort screening for memory concerns ($+1.77 \pm 0.75$, $p < 0.001$), sharing a dementia diagnosis ($+1.36 \pm 1.00$, $p < 0.001$), and educating caregivers ($+1.41 \pm 1.05$, $p < 0.001$). More students viewed dementia care as rewarding ($+0.50 \pm 1.41$, $p = 0.13$), though this was not statistically significant. Post-survey knowledge scores improved for distinguishing delirium from dementia ($+38\%$, $p < 0.05$), using screening tools for dementia ($+43\%$, $p < 0.05$), and screening tools for delirium ($+76\%$, $p < 0.05$). Knowledge of non-pharmacologic interventions, though not statistically significant, improved by 23% ($p > 0.05$). Eighty-nine percent of students found the workshop helpful.

Conclusion:

Modifications to this year's dementia workshop were associated with continued gains in student comfort with and knowledge of dementia care. Students expressed interest in more time for applied skills, which will guide future iterations. Scalable, experiential dementia education remains essential to preparing future physicians for the needs of an aging population.

C122 Student Presentation

Pilot Implementation of A Hybrid Age-Friendly Educational Series for Older Adults

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Background: Older adults often seek opportunities to expand their health knowledge and wellness beyond the clinical setting, yet such programs are limited. An academic geriatrics primary care clinic and a geriatrics workforce enhancement program partnered to pilot a monthly hybrid series, "Learn & Thrive Thursdays," to deliver age-friendly health education to patients and community members.

Methods: We developed and pilot-tested an age-friendly curriculum for urban, community-dwelling older adults. Hour-long sessions led by geriatricians or allied health professionals were held monthly on caregiver resources, nutrition, and dementia. Participants were recruited via patient portal messages (MyChart) and outreach to community partners. Attendees could join live in person or via Zoom. Post-session

evaluations used 5-point Likert scales to rate presentation quality (1=poor, 5=excellent), health knowledge, community resource knowledge, and ability to manage health (1=strongly disagree, 5=strongly agree), along with some demographic and open-ended questions.

Results: To date, 3 sessions were attended by an average of 12 individuals (range 7-20; 1-8 in-person, 5-12 online). A total of 9 post-surveys were completed; most respondents identified as non-Hispanic Black/African American (77.8%). Participants rated their overall health as good (Median: 3) and gave high ratings for the presentations (4.5), health knowledge (4), knowledge of community resources (4), and ability to manage their health (4). Most participants (8 out of 9) reported intending to make a health behavior change (e.g., increasing exercise, improving diet, joining yoga). Qualitative feedback further conveyed appreciation for sharing practical tools to improve health.

Conclusions: This pilot age-friendly educational series demonstrates the feasibility and acceptability of using a hybrid-style program for health education in a predominantly African American community. By leveraging both in-person and virtual participation, we were able to expand education beyond clinic visits which may offer a scalable model for improving equitable access to health information and supporting behavior change among older adults. Future steps include expanding to other healthcare topics.

C123 Student Presentation

Staff Perspectives on Dementia Care Training in Long-Term Care

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Background: Many long-term care (LTC) residents have dementia and require specific dementia care skills. The dementia care training front line staff receive varies in quality and efficacy at handling dementia care challenges. The purpose of this study was to describe the association between staff self-reports of preparedness and satisfaction with dementia care training to their attitudes and confidence in caring for people living with dementia (PLWD).

Methods: This was a mixed-methods descriptive study using a survey administered to non-physician staff recruited from a convenience sample of 11 nursing facilities and personal care homes in the Penn State Health Post-Acute Care network in South Central PA between August and October 2025. We visited participating facilities once to survey staff during the 2nd-shift change (1-4pm). The survey was administered via REDCap on iPads, consisted of 8 demographic questions and 2 validated instruments with Likert-scales: the 9-item Confidence in Dementia Scale (CODE) and the 15-item Sense of Competence in Dementia Care Staff Scale (SCIDS). Participants received a \$10 debit card. Analysis consisted of descriptive statistics and linear regression modeling.

Results: Most of the 143 staff from 6 participating facilities were Certified Nursing Assistants (50%) or Licensed Practical Nurses (16%), had worked in LTCs for >10 years (63%), and had been trained by the facility where they worked (69%). Staff reported they were "pretty well" (49%) or "extremely well prepared" (38%) to care for PLWD by their training. The top 3 dementia care training curricula staff reported receiving were: Positive Approach to Care™ by Teepa Snow (34%), Hand in Hand (18%) by CMS, and CARES® (14%) by the Alzheimer's Association. Mean CODE scale score (38/45) indicated high levels of confidence in dementia care skills. Mean SCIDS scale score (57/68) indicated high levels of knowledge and positive attitudes toward PLWD. Staff reporting higher levels of training and preparedness to care for PLWD rated their knowledge, attitudes, and competence in dementia care more highly.

Conclusions: LTC staff overwhelmingly reported they feel well prepared to care for PLWD. Future studies will describe the relationship between dementia care training and person-centered outcomes such as psychotropic drug use in PLWD, handling of dementia care challenges, and quality of life.

C124 Student Presentation, Encore Presentation Preparing geriatrics-trained physicians to discuss medical cannabis with their older adult patients

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Background: Older adults are increasingly using cannabis for health conditions such as pain and sleep disorders, but often use it without consultation of a healthcare provider. Concurrently, many providers feel unprepared to discuss cannabis use with patients. This educational intervention aimed to raise geriatrics-trained physician awareness and promote compassionate dialogue about cannabis use with older adults.

Methods: Thirty-one geriatric and geriatric psychiatry physicians and fellows at UC San Diego attended a synchronous online didactic series on cannabis divided into four 30-minute modules on: 1) epidemiology of use among older adults, 2) history of legalization and stigma associated with use, 3) medical evidence and patient advising, and 4) having compassionate dialogue related to use. Pre- and post-intervention evaluative data were collected (n=22 pre-test, n=13 post-test). Wilcoxon signed-rank tests were performed to assess changes.

Results: 40.9% (9) of participants were Asian Pacific Islander, 19.2% (4) Hispanic/Latino, 4.5% (1) Middle Eastern North African, 31.8% (7) White, and 4.5% (1) preferred not to answer. Statistically significant ($p < 0.05$) increases were seen in the percentage of physicians who reported being: moderately to extremely knowledgeable about medical cannabis (18.2% to 71.4%), somewhat to very comfortable initiating conversations about cannabis (22.7% to 92.9%), very to extremely confident assessing the risks, benefits, and safety of cannabis ($< 10.0\%$ to 21.2%), and very to extremely confident providing advice to patients about cannabis (0% to 14.2%).

Conclusions: This brief training series was effective in raising physicians' knowledge about, and comfort with, having conversations about medical cannabis with their older adult patients. Similar training can be easily implemented in pre- and post-doctoral settings. As more older adults opt to use cannabis as a form of therapy, physicians will need access to formal training about cannabis.

C125 Student Presentation Cardiovascular Care in Aging: An Educational Workshop for Medical Students

S. Cunningham, K. Yao, S. Saride, D. Freeland. UT Southwestern Medical Center, Dallas, TX.

Background: Physicians increasingly care for older adults with complex cardiovascular conditions. Effective management requires specialized knowledge of perioperative risk, medication side effects, geriatric syndromes, and how to elicit goals of care. Medical school curricula often lack sufficient exposure to the intersection of cardiology and aging.

Methods: An interdisciplinary workshop was developed for pre-clinical medical students. This voluntary session consisted of a case overview and four 20-minute case-based stations, collaboratively led by geriatricians and cardiologists. Stations included perioperative risk assessment for TAVR, atrial fibrillation and anticoagulation amidst fall risk, heart failure medication side effects, and end-stage heart failure goals of care conversations. Pre- and post-workshop surveys were collected to assess knowledge and attitudes about aging.

Results: Thirty-five students participated, with 26 completing both pre- and post-surveys. Likert scale responses (1 strongly disagree, 5 strongly agree) demonstrated an increased belief that knowledge about aging is relevant across specialties (mean 4.62 to 4.81), a greater awareness of how ageism impacts care (4.69 to 4.81), and a significant increase in students' desire to gain more experience with older patients (4.19 to 4.69, $p < 0.01$). Knowledge assessment

showed substantial improvement, with 92.3% correctly identifying the high fall threshold (≈ 295 annual falls) at which anticoagulation risks outweigh benefits, compared with 0% pre-workshop ($p < 0.001$).

Review of qualitative comments indicated an understanding of geriatric perioperative risk factors (frailty, cognition), adverse effects of heart failure medications (urinary incontinence, fatigue), the multi-system nature of advanced heart failure, and the nuanced effects of ageism on cardiovascular care. Students praised the workshop's interdisciplinary, clinically relevant, and interactive format, with 23.1% agreeing and 76.9% strongly agreeing that it improved their understanding of cardiovascular considerations in older adults.

Conclusion: This interdisciplinary workshop improved students' readiness to approach cardiovascular care in older adults with greater knowledge, confidence, and awareness. The demonstrated gains support incorporating this workshop into medical curricula to better prepare trainees for the realities of caring for an aging population.

C126 Student Presentation HIPE: Hands-On Interprofessional Education

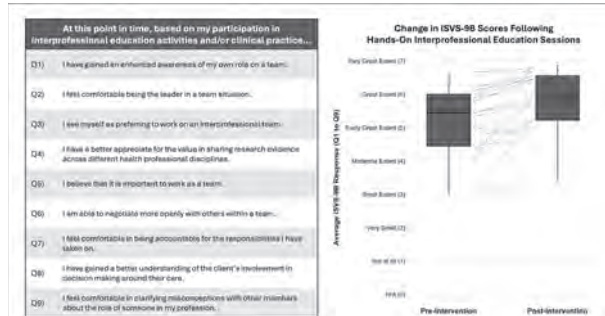
T. Basala, C. Braun, B. Ayotte, N. Kalia, S. Dowker, K. Zietlow. University of Michigan Medical School, Ann Arbor, MI.

Background: Interprofessional collaboration is essential for delivering high-quality patient care for older adults. Pre-clinical medical students often have limited exposure to allied health professionals and interprofessional education (IPE).

Methods: We created the HIPE series at our institution to provide pre-clinical medical students with early exposures to allied health professionals and IPE. Each session was led by an allied health professional, aligned with curricular content, and had a "hands-on" component (e.g., a respiratory therapist teaching ventilator management during a pulmonology block). Medical students completed the validated 9-item Interprofessional Socialization and Valuing Scale (ISVS-9B) before and after the sessions.

Results: A total of 21 participants participated in a HIPE session. Most participants identified as Female (62%), and White (38%) or Asian (38%) race. The median age was 24-years (interquartile range [IQR]: 23-25). HIPE sessions increased median ISVS-9B scores by +0.50 points (95% confidence interval [CI]: 0.28-0.89), from 5.44 (IQR: 4.44-6.00) to 5.89 (IQR: 5.22-6.56) ($p < 0.001$). ISVS-9B items two (+1.00 [95% CI: 0.00-1.50]; $p = 0.004$), three (+1.50 [95% CI: 1.00-2.00]; $p = 0.007$), four (+1.00 [95% CI: 1.00-1.50]; $p = 0.006$), six (+1.50 [95% CI: 0.50-2.00]; $p = 0.007$), eight (+1.50 [90% CI: 1.00-2.00]; $p = 0.003$), and nine (+2.00 [90% CI: 1.00-3.50]; $p = 0.005$) increased following HIPE sessions (see figure).

Conclusions: HIPE sessions improved attitudes towards interprofessional collaboration among pre-clinical medical students. Early exposure to allied health professionals in health care training programs may translate to team-based patient care for geriatric patients.



Left: ISVS-9B items. Right: Box-and-whisker plots showing pre- and post-intervention ISVS-9B scores, with participant-level changes indicated by dotted lines.

C127 Student Presentation

How does BMI impact perioperative outcomes in trauma patients undergoing ORIF for Proximal Humerus Fractures?

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Background: Proximal humerus fractures are the second most common fracture in older adults. Obesity is increasingly prevalent in this population and has been linked to higher surgical risk in other orthopedic conditions. The American College of Surgeons National Surgical Quality Improvement Program provides validated thirty-day perioperative outcomes. This study evaluates whether obese older adults undergoing open reduction and internal fixation for proximal humerus fractures experience worse short-term outcomes than patients with normal body weight.

Methods: A retrospective review of this national database identified patients sixty-five years or older who underwent open reduction and internal fixation for proximal humerus fractures. Patients were grouped by body mass index as underweight, normal weight, overweight, or one of three obesity classes. Multivariable statistical models adjusted for age, sex, and preoperative physical status assessed thirty-day reoperation, readmission, and complications. Major complications were defined as cardiac arrest, myocardial infarction, stroke/CVA, ventilator for greater than 48 hours, postop dialysis/renal failure, septic shock, sepsis, PE and unplanned intubation, while minor complications were defined as wound disruption, delirium, organ space SSI, blood transfusion, Clostroides Difficile, DVT, pneumonia, renal insufficiency, superficial SSI, UTI, and deep SSI.

Results: A total of 4168 patients met inclusion criteria, with 35.2% classified as obese. The patient population's demographic for age is 74.3 ± 7.0 and for BMI is 28.5 ± 7.1 . The gender breakdown is 79.8% female and 20.1% male. Underweight patients did have significantly higher rates of reoperation and minor complication rates (OR 2.470 and 1.67; $p = 0.026$ and $p = 0.042$, respectively) compared to normal weight patients. However, overweight, class I, II and III morbid obesity did not show any significant differences in reoperation, readmission, major, and minor complications rates.

Discussion: Obesity did not increase short-term surgical risk following repair of proximal humerus fractures in older adults. In contrast, underweight patients demonstrated higher risk and may require closer perioperative monitoring.

C128 Student Presentation, Encore Presentation

The Associations of Iron Deficiency with Functional Status and Quality of Life in Patients with Heart Failure with Preserved Ejection Fraction

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Background: Heart failure with preserved ejection fraction (HFpEF) is a common geriatric syndrome. Over 50% of older adults with HFpEF have iron deficiency (ID); yet, the association between ID and physical function and quality of life remains poorly characterized.

Methods: We analyzed participants enrolled in a single-center, prospective HFpEF registry at UT Southwestern. Adults aged ≥ 65 years completed the 12-item Kansas City Cardiomyopathy Questionnaire Overall Summary Score (KCCQ-OSS), 6-minute walk distance (6MWD), Short Physical Performance Battery (SPPB), and peak relative VO2 maximum (VO2peak). ID was defined as ferritin <100 ng/mL OR ferritin <300 ng/mL with transferrin saturation $<20\%$. Baseline characteristics and clinical characteristics were compared between groups. Associations between ID and outcomes was assessed using linear regression models adjusted for age and sex.

Results: 248 participants (median age 76 years [IQR: 71, 83]; 67% female; 26% Black) were included. ID was not associated with

differences in 6MWD (adjusted mean difference[95% CI]: 2.9m [-28.6,34.5]; $p=0.85$). Participants with ID had numerically lower KCCQ-OSS, however, differences were not significant (mean difference[95% CI]: -1.7 points [-8.9,5.5]; $p=0.64$). Among the subset with SPPB data ($n=80$), scores were similar between groups. In the subset with CPET data ($n=82$), relative VO2peak was numerically lower among those with ID without significant difference (mean difference[95% CI]: -0.5 mL/kg/min [-2.2, 1.3]; $p=0.60$).

Conclusion: ID was not significantly associated with physical function, exercise capacity, or patient-reported health status. These findings suggest heterogeneity in the impact of ID across HFpEF populations and highlight the need for larger longitudinal studies to better characterize how ID impacts functional outcomes and identify subgroups that may benefit from targeted iron repletion.

C129 Student Presentation

The Social Context of Surgical Pain: Applying the Biopsychosocial Model to Older Adults

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Background:The social context in which older adults experience surgery plays a critical role in shaping their pain experiences. Many older adults face social isolation and reduced support. These factors affect their ability to adhere to treatment plans. Although the biopsychosocial model of pain is well established in chronic pain management, its social dimensions have not been explored in acute perioperative care. This study examines the social factors within the biopsychosocial framework that influence acute pain experiences in older adults undergoing surgery.

Methods:We used semi-structured interviews to ask patients about their experiences with pain management and psychological contributors to pain at 1-7 days post-surgery. We utilized convenience sampling to recruit patients 65 years or older undergoing major surgery at Memorial Hermann Hospital in the Texas Medical Center. Participants were excluded if they had significant cognitive impairments. The participant responses were analyzed using abductive thematic analysis with the biopsychosocial model of chronic pain to frame the data.

Results: Among the nine participants, the mean age was 68, with 56% male and 56% African American. Our preliminary findings support social themes that shape perioperative pain experience. These include ageism, culture, and support. Ageist assumptions led to feelings of isolation. Cultural norms influenced pain expression. And increased levels of support related to more positive pain experiences (Table 1).

Conclusion: Our preliminary findings demonstrate that social factors shape acute perioperative pain experiences in older adults. Understanding these social dimensions in perioperative care can improve pain management and promote effective surgical care.

Table 1. Components of the social domain of the biopsychosocial model of acute perioperative pain

Category	Example Quotes
Culture	"I believe in the Lord too, so I know he going to make it all right and all better. Thats what I'm holding on to."
Ageism	"Nobody was really explaining [anything] to me; [...] And I think that's because they see this gray hair and they think she real old and senile, but that's not the case."
Support - Physical	"My friend will get me groceries and food, probably help me cook or whatever. She's been there for me before."
Support - Emotional	"I talk to my friends, and the pain kind of just vanishes."

C130 Student Presentation

Alignment in Patient and Geriatrician Priorities among Older Adults on Dialysis

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Background: Because what matters most is not routinely assessed for older adults on dialysis, many older adults on dialysis may receive care that does not align with their priorities. This study quantified the alignment between patient-identified and geriatrician-identified priorities among older adults on dialysis.

Methods: This secondary analysis included 48 participants from the Dialysis Geriatric Care Model study. Participants completed a self-administered battery of validated instruments screening for geriatric problems across six domains: activities of daily living (ADLs), cognition, falls, mood, and social support, then ranked up to two priorities from the list of identified problems. Participants also underwent a geriatrician video visit in which the geriatrician independently assessed the same domains and selected up to three problems that they deemed were a priority for management. For analysis, each patient- and geriatrician-identified priority was treated as an independent observation. Statistical analysis was performed to calculate the proportion of participant-identified priorities that were also selected by the geriatrician. Descriptive statistics, frequencies and proportions were computed using SAS 9.4.

Results: Among 48 participants, 20 (41.7%) were women, 35 (72.9%) identified as Black race, and 8 (16.7%) as Hispanic/Latino ethnicity. Mean age was 68.0 (SD 7.6) years. Participants identified 87 priorities, the most common were falls (23, 26.4%), ADLs (11, 12.6%) and nutrition (10, 11.5%). The geriatrician identified 93 priorities, the most common were falls (29, 31.2%), cognition (28, 30.1%), and nutrition (18, 19.4%). Of the 87 participant-identified priorities, the geriatrician also selected 34 (39%). Alignment by domain: falls (14 of 23, 60.9%), nutrition (6 of 10, 60%), ADLs (5 of 11, 45.5%), cognition (4 of 9, 44.4%), mood (4 of 9, 44.4%) and social support (1 of 7, 14.2%).

Conclusions: For 4 of 6 geriatric domains, ADLs, cognition, mood, and social support, most geriatrician-identified priorities did not align with participant-identified priorities. Routinely asking patients on dialysis about their priorities may help achieve more patient-centered care.

C131 Student Presentation

Preoperative Tibial Quantitative Ultrasound T-scores Correlate With Intraoperative Bone Quality in Primary Total Knee Arthroplasty

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Background: Poor bone quality in older adults contributes to intraoperative challenges and postoperative complications in total knee arthroplasty (TKA). Because intraoperative physician assessment is subjective, tibial T-scores may offer an objective measure to guide fixation. Portable quantitative ultrasound (QUS) provides a rapid, radiation-free method to obtain these T-scores, but their relationship to intraoperative bone quality remains unclear. This study evaluated that association in primary TKA.

Methods: Patients undergoing primary TKA at a single institution (June 2024-November 2025) received preoperative tibial T-score measurement using the Omni QUS device. Intraoperative bone quality was graded by a fellowship-trained orthopedic surgeon, who was blinded to QUS results, using the Intraoperative Physician Assessment (IPA), a standardized 1-5 scale of keel punch resistance, cortical resistance, cancellous quality, and pin stability. Associations between

T-score and cortical resistance were evaluated using Spearman correlation, multivariable linear regression, and ordinal logistic regression.

Results: Sixty-five patients were included. Cortical resistance showed the strongest association with tibial T-score and was used for analysis. T-score correlated with cortical resistance ($p = 0.44$, $p = 0.0017$). In multivariable linear regression, each 1-point increase in cortical resistance corresponded to a 0.55-point higher T-score ($\beta = 0.55$, 95% CI 0.11–0.99, $p = 0.015$). In ordinal logistic regression, each 1-point increase in T-score doubled the odds of a higher cortical resistance category (OR = 2.00, 95% CI 1.31–3.06, $p = 0.001$).

Conclusions: Preoperative tibial QUS T-scores showed a mild-to-moderate positive correlation with intraoperative cortical resistance in primary TKA. QUS may provide a rapid, portable, radiation-free method to assess bone quality in older adults and help identify patients at higher risk for aseptic loosening or in need of cemented fixation. Multi-surgeon studies are needed to validate QUS as a geriatric arthroplasty screening tool.

C132 Student Presentation

Causes of Itch in Older Adults: A Basic Science Perspective

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Background: Pruritus is an unpleasant cutaneous sensation that triggers the urge to scratch. Chronic pruritus, defined as itch lasting for 6 weeks or longer, affects approximately 22% of the U.S. population and is particularly common among older adults. Aging skin undergoes marked alterations in structure, immune responsiveness, and neural signaling, predisposing older individuals to persistent itch and reduced quality of life. The objective of this study was to synthesize current evidence on age-related biologic changes contributing to chronic pruritus, with emphasis on barrier, immune, and neural mechanisms.

Methods: We performed a narrative review of published studies evaluating pruritus in aging, focusing on dermatologic, immunologic, and neurocutaneous pathways implicated in itch pathophysiology. Eligible studies discussed age-associated alterations in skin barrier composition, immune function, peripheral nerve structure, or neuropeptide signaling relevant to itch pathophysiology. Extracted data were summarized across domains, including mechanistic findings, clinical correlates, and implications for management.

Results: Aging is accompanied by multiple cutaneous changes, including reduced lipid synthesis, defective barrier repair, increased transepidermal water loss, elevated skin surface pH, and shifts in the skin microbiome. Immunosenescence diminishes immune surveillance, while “inflammaging” promotes chronic low-grade inflammation amplifying pruritic signaling. Structural and functional remodeling of peripheral nerves – such as altered epidermal nerve fiber density and dysregulated neuropeptide release – further sensitizes the itch pathway. The interplay of these factors produces a multifactorial syndrome often refractory to standard therapies. Lack of objective diagnostic tools and minimal visible skin changes complicate identification of the dominant mechanism in individual patients.

Conclusion: The pathogenesis of chronic itch in older adults is multifactorial, involving barrier impairment, immune dysregulation, and neural sensitization. Targeted interventions and improved diagnostics addressing these pathways are essential to reduce symptom burden and improve quality of life.

C133 Student Presentation

Evaluating Frailty and Quality of Life Outcomes in Low-Income, Uninsured Men with Prostate Cancer

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Background: We evaluated frailty across multiple domains and examined its association with prostate cancer (PCa)-specific health-related quality of life (HRQoL) outcomes in low-income, uninsured men enrolled in the Improving Access, Counseling and Treatment for Californians with Prostate Cancer (IMPACT) Program.

Methods: We retrospectively assessed frailty using a deficit accumulation frailty index, derived from the RAND SF-12v2 (12-Item Short Form Survey, version 2), California Health Interview Survey (CHIS), and Total Illness Burden Index for Prostate Cancer (TIBI-CaP). PCa-specific HRQoL was measured at IMPACT enrollment, using the UCLA Prostate Cancer Index (PCI), which covers urinary, sexual, and bowel function and bother. We analyzed associations between frailty status and PCI domains using multivariable logistic regression.

Results: Among 358 participants (mean age 60; 68% Hispanic), 25% were frail, 45% were pre-frail, and 30% were non-frail. Across all PCI domains, PCa-specific HRQoL was significantly worse in the pre-frail and frail groups. Sexual function demonstrated the greatest impairment (mean $\pm$ SD: non-frail 54.1 $\pm$ 33.9 vs pre-frail 38.2 $\pm$ 31.3 vs frail group 24.6 $\pm$ 28.9, $p < 0.0001$). After covariate adjustment, frailty remained independently associated with worse PCa-specific HRQoL across all PCI domains, while pre-frailty showed clinically significant worse urinary bother (estimate (SE): -12.5 (5.1), $p = 0.0151$), sexual function (-14.8 (4.4), $p = 0.0009$), and sexual bother (-22.2 (5.8), $p < 0.0001$) compared with non-frailty.

Conclusions: Frailty is significantly associated with poorer PCa-specific HRQoL in low-income, uninsured men. These findings suggest that comprehensive frailty assessment has a role in stratifying risk of HRQoL reduction and guiding personalized interventions to improve genitourinary dysfunction and bother in men with PCa.

Frailty group comparison of adjusted PCI estimates (N=358)

Estimate (SE)	PCI					
	Urinary Function	Urinary Bother	Sexual Function	Sexual Bother	Bowel Function	Bowel Bother
Frail	-15.8 (4.2)	-29.1 (6.1)	-29.0 (5.3)	-27.2 (6.8)	-15.8 (3.0)	-23.4 (4.8)
p-value	0.0002	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001
Pre-frail	-7.8 (3.6)	-12.5 (5.1)	-14.8 (4.4)	-22.2 (5.8)	-4.1 (2.3)	-8.3 (4.1)
p-value	0.0391	0.0151	0.0009	0.0001	0.1011	0.0385

a) no frail used as reference

b) p-value < .0083 is significant after Bonferroni correction

C134 Student Presentation

Evaluating the impact of a fall prevention program on physical activity and quality of life in older adults: a pilot study

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Background: In the United States, falls are the leading cause of injury and injury-related death in people over the age of 65. Multiple systematic reviews and meta-analyses have demonstrated the effectiveness of fall intervention and exercise programs, such as Tai Chi, at reducing the rate and risk of falls. Other research has demonstrated the positive effect of exercise interventions on self-efficacy, fear of falling, and balance. Few studies have examined the relationship between participation in a fall prevention class and its translatable improvement in balance, mobility, and fall prevention, as measured by a quantitative increase in physical activity.

Methods: Participants in a 12-week fall prevention course were recruited in September 2024. The primary outcome measured was an average daily step count. Secondary outcomes included balance, mobility, fall self-efficacy, and quality of life. Consenting participants underwent pre- and post-course testing utilizing a pedometer,

standardized tests of balance and mobility, and questionnaires of self-efficacy and quality of life. Data were analyzed using descriptive statistics and Wilcoxon signed-rank tests; significance was indicated by p-values < 0.05.

Results: Nine community-dwelling older adults with a mean age of 73 (SD=3.3) participated in the fall prevention course. To be included in the analysis, an attendance threshold of 80% was met (n=8). There was no statistically significant difference in average daily step counts ($p = 0.25$, n=8) or balance from pre- to post-test, as measured by Fullerton Advanced Balance scale ($p=0.16$, n = 7). There was a trend towards improvement in median pretest time (6.2s) vs. posttest time (5.6s) as measured by the 8ft up-and-go ($p=0.09$, n = 7) and in fear of falling as measured by the Fall Efficacy Scale ($p = 0.094$, n = 8). There was no statistically significant difference in health-related quality of life ($p=0.63$).

Conclusion: Overall, there was no significant change in quantifiable measures of physical activity, balance, mobility, or in quality-of-life after completion of a 12-week fall prevention course. There were trends toward significance in decreasing fear of falling and increasing balance and mobility. Further refined future studies would help elucidate the trends observed in this pilot study to better understand the role fall prevention courses have on physical activity, balance, mobility, and quality of life.

C135 Student Presentation, Encore Presentation

Cannabis Use Among Caregivers of Older Adults: A Systematic Literature Review

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Background: As the global population of older adults grows, the number of caregivers has risen accordingly. Though caregiving has many rewards, it may also cause psychological stress. To manage this burden, caregivers may adopt various coping strategies, including the use of cannabis. This review aims to synthesize existing literature on cannabis use among caregivers for older adults.

Methods: In January 2025, a systematic search in PubMed, PsycINFO, and CINAHL following PRISMA guidelines identified peer-reviewed studies published after 1996, when cannabis was first legalized in the United States, that provided empirical data on cannabis use among caregivers for older adults. The search strategy used three keywords ("caregiver", "cannabis", and "use") and their associated terms.

Results: 357 unique studies were screened, 39 studies were assessed for eligibility, and 5 studies were included in the review. Of the included studies, published between 2020-2024, four performed cross-sectional analyses, one conducted focus groups, and four took place in the US. Sample sizes ranged from 26 to 10,444. Four studies found that caregivers with high reported stress or emotional burden used cannabis to cope, with two studies finding new or increased use occurring during the COVID-19 pandemic. One study found that using cannabis improved caregivers' self-reported health and well-being; another found positive caregiver attitudes toward recreational cannabis. Two studies found higher caregiver anxiety was associated with increased cannabis use. One study found greater cannabis use among caregivers who were non-White, younger, parents, or those with insomnia, higher financial strain, or higher education.

Conclusions: Although research on this topic is limited, these studies underscore the role of cannabis as a potential coping mechanism for caregivers of older adults experiencing emotional burden. Additional research is needed to characterize longitudinal patterns of cannabis use among caregivers and its potential impacts on both caregivers and care recipients.

C136 Student Presentation

The Relationship between Axial Length and Severity of Glaucoma in Primary Open Angle Glaucoma

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Background: Glaucoma is the leading cause of irreversible blindness across the world. Myopia, a condition associated with a longer axial length has often been considered a risk factor for glaucoma but it is unclear whether different axial lengths play a role in determining the severity of glaucoma. This research project aims to examine patients across a wide range of axial lengths to determine whether certain lengths are correlated with an increased severity of glaucoma with the use of cup-to-disc ratio (CDR), average retinal nerve fiber layer (RNFL), mean deviation (MD), visual field index (VFI), and pattern standard deviation (PSD) as measures for the severity of glaucoma.

Methods: A retrospective chart review of 105 patients (mean age: 76.94 ± 8.48) with primary open-angle glaucoma (POAG) was constructed. We then conducted correlational and linear regressions for each of the five variables of glaucoma severity. CDR tertile groups were created in order to determine if at specific CDR values, an association between glaucoma severity and axial length could be found.

Results: Correlation analyses for the entire dataset showed mean deviation (MD) was statistically significant and negatively correlated with axial length (Spearman's $\rho = -0.22$, p -value = 0.0234). In the multivariable regression, when controlling for Tmax, disc area, age, and CCT for every 1mm increase in axial length, there was a 0.88 dB decrease in the mean deviation ($\beta = -0.88$; 95% CI: -1.71 to -0.05; $p = 0.039$). When divided into subgroups, the moderate CDR group ($0.6 \leq \text{CDR} \leq 0.8$) showed a statistically significant linear regression between axial length and MD ($\beta = -1.73$, 95% CI -3.27 to -0.20, $p = 0.029$).

Conclusion: Our results have shown that increased axial length correlated with a more negative mean deviation. When looking at specific CDR subgroups, the same results were found but only for the moderate CDR group ($0.6 \leq \text{CDR} \leq 0.8$). Future studies are encouraged to increase the sample size and also incorporate a longitudinal component to further determine whether this association holds true and if there is a faster progression of glaucoma in patients with longer axial lengths.

C137 Student Presentation

Prevalence and Severity of Dry Age-Related Macular Degeneration in Primary Open Angle Glaucoma

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Background: Dry age-related macular degeneration (AMD) is characterized by damage to the retinal pigmented epithelium of the macula resulting in fatty drusen deposits and is the leading cause of blindness in adults over 60. Primary open-angle glaucoma (POAG) is a progressive optic neuropathy that is the second leading cause of blindness worldwide, thought to be mainly caused by elevated intraocular pressure and impaired vascular perfusion. Although both are thought to involve perfusion deficits and ischemic injury, it remains unclear whether these causes of vision loss converge on a shared vascular-neurodegenerative pathway. The objectives of this study are to determine the prevalence of dry AMD in patients with POAG and whether there is a relationship between the severity of POAG and dry AMD.

Methods: This retrospective cohort study included all patients seen at UT Southwestern's glaucoma clinic between April 18 and August 18, 2025, with a suspected diagnosis of POAG. Visual field loss and OCT parameters were used to stage glaucoma, while OCT and fundus photographs were reviewed for AMD diagnosis. In patients with asymmetric disease (eyes differ in severity), odds ratio (OR), McNemar's, Binomial Exact, and Wilcoxon tests assessed concordance between the worse glaucoma and dry AMD eyes.

Results: Among 500 patients (1000 eyes), the average age was 70.4, with 87% of patients older than 60, 274 (54.8%) female, and AMD was present in 133 (13.3%) eyes (Table 1). POAG diagnosis was significantly associated with AMD (OR=2.04) ($p=0.008$). Adjusting for age and gender weakened the association (OR=1.65) ($p=0.077$). The association was significant in males (OR=3.05) but not females (OR=1.64). In asymmetric glaucoma patients ($n=253$), the worse glaucoma eye more frequently had AMD (McNemar $p=0.041$) and higher AMD severity (Wilcoxon $p<0.001$). Of the 36 patients with asymmetric POAG and AMD, parallel alignment occurred in 31 (86%) ($p < 0.001$).

Conclusion: Study results suggest that there is an association between POAG and AMD severity. Future analysis of systemic comorbidity data and OCTA parameters may reveal shared vascular susceptibilities and identify potential therapeutic targets.

POAG Staging	(n=1000)	AMD Staging	POAG + AMD (n=133)
Healthy/Normal	75(7.5%)	AMD Suspect	64 (48.1%)
Ocular Hypertension	127(12.7%)	Early Dry AMD	24 (18%)
Glaucoma Suspect	242(24.2%)	Intermediate Dry AMD	33 (24.8%)
Mild POAG	137(13.7%)	Advanced Dry AMD	10 (7.5%)
Moderate POAG	228(22.8%)	Exudative AMD	20 (15%)
Severe POAG	157(15.7%)		
Advanced POAG	34(3.4%)		

Table 1: Distribution of POAG and POAG + AMD eyes

C138 Student Presentation

Feasibility of Assessing Dyadic-Outcomes Among Older Adults and Family Caregivers in the Intensive Care Unit

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Background: Critical illness poses high risks to older adults, with substantial mortality, morbidity, and functional decline following intensive care unit (ICU) admission. ICU stays may also cause substantial stress for patients and family caregivers, yet longitudinal impacts on wellbeing remain poorly characterized. We conducted a pilot prospective cohort study of older adult-caregiver dyads to assess the feasibility of capturing longitudinal patient- and family-reported outcomes from ICU admission to 3 months post-discharge.

Methods: We included older adults (age ≥ 65) and their caregivers admitted to an ICU at a single academic medical center. Baseline clinical and demographic data were collected from the electronic medical record, and validated patient- and caregiver-reported measures were used to assess quality of life, psychological distress and financial toxicity. Outcomes were assessed during ICU stay, within 30 days of hospital discharge, and at 3-months post-discharge via standardized interviews and emailed survey instruments. Caregivers of decedents were interviewed at 3 months. Feasibility was evaluated through recruitment, retention, and survey completion rates.

Results: We enrolled 31 dyads/ 120 approached (26%) over 6 months. The mean age of enrolled patients was 73; 39% of whom were female, 26% Black, and 71% White. 39% ($n=12$) of patients died during the study period, mostly during the index admission ($n=9$). Mean ICU and hospital stays were 11 and 17 days, respectively. Of surviving patient-caregiver dyads, 12/20 (60%) completed surveys within 1 month of hospital discharge, with fewer completing 3-month assessments (7/20; 35%). 5/12 caregivers of decedents participated in follow-up interviews. Respondents lost to follow up did not significantly differ from those who followed up in terms of demographics or care characteristics; however, they more frequently reported financial strain at baseline.

Conclusions: Enrollment and baseline data collection are feasible among older ICU patients and caregivers. However, high mortality and follow-up challenges limit long-term data capture, underlining the potential stresses of critical illness in this population and the need for approaches such as proxy-reported outcomes and minimally burdensome follow-up methods.

C139 Student Presentation

Radiographic Sarcopenia as a Prognostic Marker of Early Clinical Outcomes in Intertrochanteric Hip Fractures

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BACKGROUND: Sarcopenia is increasingly recognized as a prognostic marker in orthopedic surgery. Traditional assessments face barriers including cost, radiation, and equipment needs. Recent studies show radiographic thigh measurements correlate well with gold-standard techniques. We hypothesized patients meeting radiographic criteria for low muscle mass would experience increased mortality following intertrochanteric fracture fixation.

METHODS: This IRB-approved retrospective study analyzed consecutive patients (>60 years) with intertrochanteric fractures treated with cephalomedullary nails (January 2017-December 2019). Radiographic measurements: AP thigh muscle thickness 15 cm proximal to adductor tubercle, lateral quadriceps thickness 15 cm proximal to Blumensaat line. Sarcopenia required both below thresholds: thigh muscle <12.47/10.68 cm and quadriceps <3.23/2.20 cm (men/women respectively). Primary endpoint: 30-day mortality. Secondary: length of stay, complications, discharge disposition, readmissions. Analysis used Mann-Whitney U and Fisher's exact tests ($p < 0.05$).

RESULTS: Among 126 patients, sarcopenia prevalence was 44% (56/126), with gender disparity: 75% males versus 32% females ($p < 0.001$). All mortality events occurred in sarcopenic patients. Sarcopenia associated with increased 30-day mortality (10.7% vs 0%; $p = 0.0066$). Sarcopenic patients had lower BMI; age, length of stay, comorbidity index, and disposition showed no differences. Discharge patterns, transfusions, readmissions, and infections were similar.

CONCLUSION: This study demonstrates 44% prevalence of radiographic muscle deficiency, exceeding general elderly rates (10-24%). While all mortality events occurred below thresholds, small numbers limit conclusions. Measurements require under 2 minutes from standard radiographs without additional cost, equipment, or radiation. This establishes feasibility and baseline prevalence, though validation remains before clinical implementation.

Table 1. Baseline Characteristics & Early Mortality

Variable	No Sarcopenia (n=70)	Sarcopenia (n=56)	p-value
Age, mean $\pm$ SD (yr)	78.7 $\pm$ 9.8	77.7 $\pm$ 10.2	0.4433
Male sex, n (%)	9 (13%)	27 (48%)	< 0.001
BMI, mean $\pm$ SD (kg/m ²)	27.0 $\pm$ 5.2	22.9 $\pm$ 6.5	0.000005
LOS, mean $\pm$ SD (days)	6.7 $\pm$ 3.4	6.5 $\pm$ 3.0	0.5208
In-hospital mortality, n (%)	0 (0%)	3 (5.4%)	0.0832
30-day mortality, n (%)	0 (0%)	6 (10.7%)	0.0066

C140 Student Presentation

Recognizing Primary Hyperparathyroidism in Older Women: A Case Series Highlighting Missed Diagnoses and Geriatric Outcomes

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Primary hyperparathyroidism (PHPT) is an underrecognized contributor to cognitive decline, functional impairment, and bone fragility in older adults. Despite affecting up to 2% of postmenopausal women, more than half of patients with hypercalcemia do not receive an adequate evaluation. Because symptoms of PHPT—fatigue, dizziness, memory concerns, and musculoskeletal pain—overlap with common geriatric syndromes, diagnosis is often delayed, leading to preventable morbidity in aging adults. We describe three cases of PHPT identified in women over age 70 who initially presented with nonspecific geriatric complaints.

An 81-year-old woman with nephrolithiasis developed dizziness and memory difficulties impairing her daily function. Mild hypercalcemia (10.4 mg/dL) and elevated PTH (105 pg/mL) led to imaging that identified a parathyroid adenoma; postoperative normalization of calcium was accompanied by notable improvement in attention and dizziness.

An 83-year-old woman with multiple comorbidities, severe osteoporosis, and new functional limitation from bone pain was found to have calcium levels of 10.3–10.7 mg/dL and PTH 102–108 pg/mL; ultrasound showed a likely adenoma, and she was referred for surgical management to reduce fracture risk and alleviate hypercalcemia-associated symptoms.

A 70-year-old woman presented with fatigue, memory loss, and reduced activity; evaluation revealed calcium of 10.4–11 mg/dL, PTH 147 pg/mL, and vitamin D deficiency. She was referred for endocrine surgery after repletion due to concerns about further cognitive and functional decline.

These cases highlight PHPT as an important reversible cause of geriatric syndromes. Even mild hypercalcemia in older adults warrants PTH testing to avoid missed diagnoses. Untreated PHPT may accelerate osteoporosis, falls, fractures, and cognitive impairment—conditions with major implications for independence and quality of life. Parathyroidectomy remains the only definitive therapy and can improve neurocognitive symptoms, bone health, and functional outcomes. Increased awareness among geriatric clinicians is essential to ensure earlier detection and intervention for this highly treatable condition in adults over 70.

C141 Student Presentation

Preoperative Qualitative Ultrasound Tibial T-scores and Fixation Choice in Primary TKA

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Background:

Bone quality is an important factor in determining fixation strategy during total knee arthroplasty (TKA), particularly in older adults, who may be at increased risk for cementless fixation failure. Portable, point-of-care quantitative ultrasound (QUS) devices offer a low-cost, radiation-free method of estimating preoperative bone density at the tibia, though their clinical utility in guiding cementless versus cemented tibial fixation during TKA remains unclear. This study evaluated whether tibial T-scores obtained using the OMNI QUS device were associated with intraoperative fixation choice in adults undergoing primary TKA.

Methods:

Patients undergoing primary TKA with preoperative QUS-derived tibial T-scores were identified (N = 116). QUS assessment was performed at the tibial mid-shaft using standardized manufacturer protocols. Fixation strategy was determined intraoperatively by the surgeon. Multivariable logistic regression was performed with fixation type as the dependent variable and T-score, age, BMI, smoking status, vitamin D supplementation, calcium supplementation, gender, and race as the covariates.

Results:

Tibial T-score was not significantly associated with fixation choice (OR 0.82, 95% CI 0.59-1.12, $p = 0.211$). Age was the only significant predictor of fixation, with each additional year increasing the odds of cement use by 9% (OR 1.09, 95% CI 1.02-1.16, $p = 0.016$). No significant associations were observed for BMI, smoking status, vitamin D or calcium supplementation, gender, or race.

Conclusion:

Preoperative tibial T-scores obtained using a portable QUS device did not predict cemented versus cementless fixation choice in primary TKA. Age was the only significant determinant of fixation choice, highlighting that orthopedic surgeons continue to rely on age for surgical planning. These findings suggest that QUS-derived T-scores currently have limited influence on intraoperative decision-making regarding tibial fixation. Further research is needed to determine whether QUS-derived bone quality assessment can meaningfully guide fixation strategy and add value beyond age-based decision-making in primary TKA.

C142 Student Presentation

Deepening Care Through StoryListening: A Narrative Approach to Understand Social Isolation, Loneliness, and Connectedness in Older Adults and their Caregivers

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Background: Loneliness affects 20-25% of older adults and is associated with coronary heart disease, dementia, and premature death. StoryListening (SL) has been associated with helping people process bereavement, manage emotions, and reduce stress. This project evaluates the impact of SL on loneliness and connectedness among older adults and their caregivers.

Methods: We recruited adults who were either ≥ 60 years, living in either community or non-acute care inpatient settings, or primary caregiver for an older adult. Participants completed interviewer assisted structured questionnaires (UCLA-3 loneliness, De Jong Gierveld loneliness, Watts connectedness scale (WCS), NCCN Distress Thermometer, PROMIS-10, GAD-2, PHQ-2) at baseline and at 2- and 14-days post-intervention. Trained interventionists delivered 1 SL session per participant in person or by televideo, during which they invited participants to share about times of social isolation/loneliness, or connection in a non-directive, compassionate way. All sessions were audio-recorded.

Results: 34 participants (27 community members, 5 caregivers, 2 inpatients) enrolled and completed baseline data. Among the 68% participants who completed all post-intervention surveys[RG1], 74% were white, 87% female, and 87% heterosexual. Both loneliness scores were unchanged (-0.2 ± 1.1 , $p = 0.3$; -0.2 ± 1.1 , $p = 0.5$) at 2 weeks. There was improved overall connectedness at both time points ($+9 \pm 11$ and $+6 \pm 13$; $p < 0.05$), which was largely driven by improved self-connectedness ($+21 \pm 12$ and $+15 \pm 14$; $p < 0.05$). Distress decreased at 2 weeks (-1.7 ± 2.9 ; $p < 0.05$). Quality of life, anxiety, and depression scores were unchanged.

Conclusions: Preliminary findings suggest that SL interventions may improve connectedness and reduce distress, which may represent important mechanisms towards reducing loneliness among older adults and caregivers. Future studies are needed to evaluate the effectiveness of SL within specific subgroups.

C143 Student Presentation

Cognitive Behavioral Therapy in Heart Failure Depression: Comparative Efficacy and Clinical Outcomes in Randomized Trials

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Background: Depression impacts between 17-50% of heart failure (HF) patients, and over 50% do not have their depression addressed. The remaining majority who have their depression addressed are treated with SSRI antidepressant medication, with

under 20% being treated with CBT. Identifying and understanding the most useful modality for the treatment of depression in HF is essential for optimizing psychiatric care, self-care, and potentially clinical outcomes in this vulnerable population.

Objectives: This systematic review synthesized evidence from Randomized Controlled Trials (RCTs) to assess antidepressants and CBT in the treatment of depression in HF, as well as the resultant clinical outcomes such as mental health-related quality of life (mHRQOL), physical health-related quality of life (pHRQOL), mood, cardiac-related anxiety, rehospitalizations, ED visits, mortality, memory, and insomnia.

Methods: A comprehensive literature search was conducted through PubMed. The search yielded 144 articles published between 2015 and 2025, of which 24 were RCTs. These trials were screened to 14 RCTs which met the inclusion criteria and were selected for this systematic review, which included a total of 2733 patients. Primary outcomes included depression severity changes, quality of life, rehospitalizations, and mortality.

Results: CBT interventions were found to have a significant improvement in depression, anxiety, pHRQOL, insomnia, self-esteem, ED visits, and days hospitalized compared to usual care, though this was inconsistent with self-care. CBT was found to significantly improve depressive symptoms compared to a discussion forum. A large RCT found that depressive symptoms decreased by approximately 50% in patients receiving CBT and those receiving antidepressants. Escitalopram was also found to have no improvement in HF patients with depression.

Conclusions: In light of these results and CBT being underutilized in this population compared to antidepressants, providers should consider CBT to optimize a multidimensional and interdisciplinary approach to treat this at-risk population and reduce healthcare and pill burden.

C144 Student Presentation

Primary Care Misses the Mark: Early Dementia Detection Still Elusive- A Case Highlighting the Consequences.

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Background: Dementia affects >6 million people in the U.S., and 42% of adults >55 may eventually develop it. Although dementia care has shifted into primary care since the 1980s-with adoption of screening tools, guidelines, and treatments-underdiagnosis persists due to time constraints, fragmented follow-up, and lack of structured screening. Early recognition enables use of disease-modifying therapies, cognition-enhancing medications, brain-exercise interventions, care planning, and caregiver support. High-risk adults with vascular disease, diabetes, hypertension, APOE4, or family history benefit most from proactive care. Advances in blood-based and CSF biomarkers, digital tools, and community screening further support early diagnosis. This case shows how missing primary-care evaluation delayed diagnosis.

Case: A 77-year-old female experienced a year of memory lapses, personality changes, and repetitiveness before presenting directly to neurology without primary-care evaluation. Collateral history noted temporal disorientation, repeated reminder calls, and declining confidence. MRI showed global atrophy with minimal microvascular disease; MoCA was 26/30 with intact ADLs/IADLs and unremarkable PET scan and labs. Memantine was started, but follow-up was fragmented. By age 83, MoCA was 12/30 and SLUMS of 14/30 during geriatric visits at assisted living memory-care. She repeated stories, had short-term memory loss, and was dependent on 8/8 IADLs and 1/6 ADLs. Caregiver burden required home-health support and eventual transition to memory care.

Discussion: This case demonstrates that despite decades of integrating dementia detection into primary care, routine screening remains inconsistent. Earlier screening, at age 65 or sooner for high-risk adults, may slow progression. Late diagnosis increases caregiver strain, hospitalization, and reduces patient autonomy for financial and long-term decisions. Incorporating cognitive screening into annual visits with CPT codes and adding blood biomarkers to routine labs can enhance early detection.

Conclusion: Primary-care evaluation with cognitive, functional, and mood assessment with biomarker integration improves timely diagnosis, enables therapy initiation, supports caregivers, and preserves autonomy as part of holistic dementia care.

C145 Student Presentation, Encore Presentation Fall Reflections: Identifying Risk Factors and Opportunities for Prevention

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Background: In the hospital, falls are a significant quality and safety concern; however, fall prevention is notoriously difficult. Interventions focused on reducing delirium risk have been shown to reduce rates of falls. Delirium is often underrecognized in hospital settings, and identification of delirium presents an opportunity to improve patient care. Certain medications such as sedatives have been associated with falls in the hospital. Our study aimed to describe and categorize fall-related characteristics including recognition and documentation of delirium, medications administered before the fall, and presence of hypotension to identify potentially modifiable risk factors that may reduce falls and improve patient safety at our institution's hospital.

Methods: Electronic medical records from all patients who sustained a fall at our institution's hospital from January 1, 2023 to December 31, 2024 were reviewed. Patient demographic data and factors that may have contributed to the fall were entered securely into the Research Electronic Data Capture (REDCap) software database. Descriptive statistics were used to analyze the number of falls associated with each risk factor.

Results: 181 falls occurred in the hospital from 2023-2024. Twenty percent of falls reported mild to severe injuries. The majority (58%) of falls occurred in patients over the age of 60 years old. Half of patients had a prior history of falls documented in their medical record. Over 60% of patients had a Confusion Assessment Method (CAM) screening documented 24 hours before and after the fall. Less than 10% of CAM scores documented were positive for delirium. Antihypertensive medications (30% of falls) and narcotics (18% of falls) were most commonly associated with falls. Hypotension occurred prior to 10% of falls.

Conclusions: The majority of falls occurred in older adult patients. Although the majority of patients were screened for delirium, a minority of those screened had a positive CAM score. Increasing fall precautions while a patient is receiving antihypertensive medications and narcotics, as well as improving recognition and documentation of delirium, may be able to reduce the occurrence of falls in the hospital.

C146 Student Presentation

Changes in Leg Joint Moments in Response to Altered Vertical Limb Loading during Walking in Individuals with Knee Osteoarthritis

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Background: Abnormal knee joint mechanics during walking are primary contributors to the onset and progression of knee osteoarthritis (KOA). Real-time gait biofeedback targeting vertical ground reaction force (vGRF) can directly modify gait biomechanics, address sustained aberrant compressive loading and encourage more dynamic loading, potentially promoting cartilage integrity.

Methods: Ten older adults with mild-moderate KOA completed a repeated-measures treadmill protocol. Participants completed five treadmill walking trials: the first without real-time biofeedback (habitual walking) and, in randomized order, four biofeedback conditions that cued targets of -3%, +3%, +6%, and +9% of body weight relative to habitual peak vGRF. Kinematics and vGRF were recorded on an instrumented treadmill; OpenSim estimated hip, knee, and ankle moments. Outcomes were stride-averaged peak extensor moments and their step-to-step variability (SD). Linear mixed-effects models tested condition, limb, and condition×limb interaction effects.

Results: Participants successfully modulated vGRF across targets. There was no condition×limb interaction, indicating indistinguishable capacities of involved and uninvolved limbs to accommodate altered loading. Peak knee extensor moments decreased at -3% and increased at +3%, +6%, and +9% as hypothesized, though these variations have not yet reached statistical significance at the current sample size. Hip extension moments increased most at +9% (pairwise $p=0.020$) and rose stepwise across all biofeedback conditions (overall trend $p=0.078$). Step-to-step variability increased for all joints under above-habitual targets ($p<0.0001$).

Conclusions: These findings demonstrate that adults with KOA can acutely alter lower-extremity kinetics in response to vGRF-targeted biofeedback and that neither KOA nor KOA symptoms affect participants' ability to modulate lower extremity joint moments. Elevating compressive loading to therapeutic targets coincides with greater hip extensor demand and heightened motor variability, supporting comprehensive joint-level evaluation during gait retraining.

C147 Student Presentation

Patterns of Nutritional and Psychological Vulnerability Associated With Fall Risk Among Hospitalized Older Adults: Cross-Sectional Evidence From a Tertiary Geriatric Ward in Kolkata, India

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Background: Falls represent a critical public health challenge for older adults, frequently leading to injury, prolonged hospitalization, compromised independence, and increased mortality. The annual prevalence of falls reaches one-third among adults aged 65 and over. A growing body of evidence suggests that fall risk is rarely attributable to single causes, but rather emerges from the complex, multidimensional interaction of various factors. Identifying these overlapping patterns of vulnerability is crucial for developing precise fall-risk assessment tools tailored for the hospitalized older population.

Methods

We are conducting a cross-sectional observational study within a tertiary-care geriatric ward in Kolkata, India. Participants were restricted to adults aged 60 years or older who had experienced at least one fall within the past year. Fall risk was formally quantified using

the Morse Fall Scale (MFS). Nutritional status was evaluated using the Mini Nutritional Assessment–Short Form (MNA-SF), and depressive symptoms were screened using the Geriatric Depression Scale (GDS). Data were subjected to descriptive, correlation, and pattern analyses.

Interim Results

Analysis of 105 participants revealed substantial vulnerability across all domains. 53.3% classified as malnourished and 41.9% at nutritional risk. Depressive symptoms were prevalent in nearly three-quarters of the cohort (74.3%). Furthermore, 45.7% were categorized as having a high fall risk. Notably, in the group exhibiting the dual burden of both malnutrition and depressive symptoms, approximately 65% were assigned a high fall-risk status. Preliminary correlation analysis demonstrated positive associations between MNA-SF and GDS scores (Spearman $r=0.31$), and between both psychological and nutritional measures and the MFS score.

Conclusion

These interim findings strongly suggest that hospitalized, fall-prone older adults in this setting commonly present with a significant co-occurrence of nutritional and psychological vulnerability. This distinct, clustered pattern appears to reflect a multidimensional frailty-related profile and underscores the critical need for integrated screening and holistic intervention strategies in this high-risk population.

C148 Student Presentation, Encore Presentation The Impact of Social Determinants of Health on the Obesity Status of Older Adults

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Background

Underserved older adults attending the student-run free clinic (SRFC) may be especially vulnerable to overlapping socioeconomic barriers, making them an important group for targeted obesity interventions that take into account each individual's broader social environment. However, further research is needed to investigate the correlation between specific social determinants of health (SDOH) and older adults with obesity. Therefore, our research question is: which SDOH most affect the older adult patients with obesity at the SRFC in Indianapolis, Indiana?

Methods

In this IRB-exempt (IUHRPP #26807) study, we utilized the electronic medical record (EMR) system at our SRFC to collect SDOH and BMI for all 89 older adult patients aged 65 and older seen at our SRFC since the beginning of 2024. We collected the zip code Distressed Community Index (DCI), age, gender, race, and comorbidities for each patient. We then made graphs to visualize correlations between each SDOH and obesity status for the patients in our study.

Results

Among 89 older adult patients at the SRFC, obesity (BMI ≥ 30) was significantly associated with type 2 diabetes ($p < 0.001$). No significant associations were found between obesity and hypertension ($p = 0.11$), hyperlipidemia ($p = 0.56$), or osteoarthritis ($p = 0.078$), though the latter showed a suggestive trend. Gender was not significantly associated with obesity status ($p = 0.063$), though a trend was observed with more females classified as obese. Race and age were not significantly associated with BMI. A Spearman correlation indicated a moderate negative monotonic relationship between zip code-level BMI and the Distressed Community Index (DCI), but this did not reach statistical significance ($p = 0.075$).

Conclusion

In this older adult population at the SRFC, type 2 diabetes was strongly linked to obesity, while other comorbidities showed no statistically significant associations. Obesity trends in gender distribution and community-level socioeconomic distress highlight areas for

further investigation. These findings emphasize the need for SRFCs to consider both clinical and social determinants in obesity-related care. By identifying older adult patients at high risk for obesity based on SDOH, SRFCs nationwide can create targeted interventions to promote equitable health outcomes among underserved older adults.

C149 Student Presentation

Mindfulness Predicts Depressive Symptoms Among Nursing Home Certified Nursing Assistants

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Background: Depression among nursing home (NH) certified nursing assistants (CNAs) became the topic of an emerging body of research during the COVID-19 pandemic, with research indicating prevalence rates as high as 47%. New strategies are needed to support NH workforce well-being. This study examined post-pandemic associations between CNA depressive symptoms and individual and organizational factors. Method: Participants ($n = 283$) were predominantly White (84.5%), non-Hispanic (86.2%), and cisgender women (80.9%), with a mean age of 32.13 ($SD = 13.00$). Participants were recruited from NHs across Wyoming and completed a survey assessing factors related to well-being and occupational outcomes. A hierarchical regression examined predictors of depressive symptoms (PHQ-8) among NH CNAs. Length of CNA experience; workplace violence (WPV; Workplace Violence Questionnaire); environmental factors such as supervisor and coworker support (Leiden Quality of Work Questionnaire) and team inclusion (Health Care Team Inclusion Questionnaire); and coping variables, such as problem-focused coping (Brief COPE) and mindfulness (Mindful Attention Awareness Scale) were entered in four steps. Results: The final model was significant, explaining 36% of the variance in depressive symptoms ($F(7,275) = 22.20$, $p < .001$; $R^2 = .36$). Length of CNA experience was not a significant predictor. Adding WPV significantly improved the model ($\Delta R^2 = .07$, $p < .001$), with WPV significantly predicting depressive symptoms ($\beta = .26$, $p < .001$). Adding environmental factors also improved model prediction. WPV remained significant ($\beta = .17$, $p = .006$), whereas supervisor support, coworker support, and team inclusion were not significant predictors. In the final model, coping variables significantly improved the model, with mindfulness as a strong negative predictor ($\beta = -.54$, $p < .001$). WPV was no longer a significant predictor of depressive symptoms ($\beta = .05$, $p = .31$). Conclusion: Findings suggest that mindfulness may protect against depressive symptoms even in the face of WPV, underscoring the potential value of mindfulness-based interventions to support the well-being of NH CNAs exposed to occupational stressors.

C150 Student Presentation

Examining Organizational and Individual Factors Related to Moral Distress Among Nursing Home CNAs

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Background: Moral distress occurs when individuals must act in ways that conflict with their values, beliefs, and morality. It is a prevalent concern among nursing home (NH) staff and is linked to low job satisfaction and performance, high turnover intent, and poor mental health. However, factors related to moral distress have yet to be studied among certified nursing assistants (CNAs) in NHs. Method: Participants ($n = 286$) were predominantly White (83.6%), non-Hispanic (85.3%), cisgender women (80.1%), with a mean age of 32.13 ($SD = 13.00$). Participants were recruited from NHs across Wyoming and completed a survey assessing factors related to well-being and occupational outcomes. A hierarchical multiple regression was conducted to examine predictors of moral distress (ProQOL Health)

among CNAs. Length of CNA experience was entered at Step 1, workplace and environmental factors at Step 2, and coping variables at Step 3. Results: CNA tenure significantly predicted higher moral distress at Step 1 ($\beta = .12, p = .049$). In Step 2 ($\Delta R^2 = .30, p < .001$), higher workplace violence (Workplace Violence Questionnaire) significantly predicted greater moral distress ($\beta = .21, p < .001$), whereas supervisor support (Leiden Quality of Work Questionnaire) predicted lower moral distress ($\beta = -.26, p < .001$). In the final model, coping variables significantly improved the model ($\Delta R^2 = .08, p < .001$). Specifically, mindfulness (Mindful Attention Awareness Scale) was a significant negative predictor ($\beta = -.26, p < .001$), and problem-focused coping (Brief COPE) was a significant positive predictor ($\beta = .12, p = .015$). Workplace violence ($\beta = .14, p = .006$) and supervisor support ($\beta = -.19, p = .006$) remained significant. Conclusion: These findings indicate that organizational and individual factors shape CNAs' moral distress. Workplace violence and low supervisor support were linked to greater distress, while mindfulness appeared protective. Greater use of problem-focused coping was associated with higher distress, possibly reflecting systemic barrier frustration. Interventions that enhance supervisor support and promote mindfulness may help reduce moral distress and support CNA well-being.

C151 Student Presentation

Shortage Stress: Mental Health Effects of Prescription Drug Unavailability for Older Adults

C. Kricorian, K. Turner. *Researcher, For Good Measure, Simi Valley, CA.*

Background

In 2024, the American Society of Health-System Pharmacists (ASHP) reported 323 prescription drug shortages, the highest number ever. Being unable to obtain necessary medication is likely to be stressful, but little research has been conducted on the psychological effects older patients experience when they are unable to obtain necessary medicines.

Methodology

Data were analyzed from the February 2025 wave of the U.S. Census Bureau's Household Trends & Outlook Pulse Survey (HTOPS). The survey collected data on N=6,740 adults, including N=2,039 people aged 65 and older. Variables measured by the survey included ability to obtain necessary prescription drugs, overall life satisfaction and PHQ-4 measures of emotional health. Data were analyzed using chi-square tests.

Results

Among older adults surveyed, 5.1% reported being affected by medication shortages in the last 4 weeks. Older adults who experienced these medication shortages were markedly less likely to say they were "completely satisfied" with their lives than those who did not experience medication shortages (10.4% vs. 17.6%, $p < .05$). Those who had not experienced medication shortages had significantly better results on all PHQ-4 metrics: they were more likely to say they were "not at all" anxious in the past 2 weeks (62.2% vs. 47.2%, $p < .05$), "not at all" worried (73.0% vs. 54.0%, $p < .05$), "not at all" having little interest or pleasure in doing things (78.8% vs. 55.8%, $p < .05$) and "not at all" down or depressed (74.9% vs. 58.9%, $p < .05$).

Conclusions

Many older adults were unable to access their necessary medications due to prescription drug shortages. Personally experiencing a drug shortage was associated with an array of negative psychological metrics for older adults, including worse outcomes on all 4 measures of the PHQ-4 and lower overall life satisfaction. These data highlight the negative psychological effects that medication unavailability has on older patients, which may compound the health impacts of missing required medications. While further research is needed, the data contribute to our understanding of the broader effects of drug shortages on older adults.

C152 Student Presentation

Arts Participation and Anxiety among Older Adults

C. Kricorian. *Research Intern, For Good Measure, Simi Valley, CA, CA.*

Background

Recent reductions in community arts funding may negatively affect older adults. Studies on the benefits of arts participation have focused on the impact of specific interventions, such as theater or visual arts programs on specific patient populations, such as those experiencing dementia or cancer. Surprisingly little quantitative research has been conducted on the effects of arts participation on broader community mental health among older adults.

Methodology

Data were analyzed from the February 2025 wave of the U.S. Census Bureau's Household Trends & Outlook Pulse Survey (HTOPS). A total of N=2,039 people aged 65 and older completed the survey, and variables measured included level of anxiety and arts participation. Data were analyzed using chi-square tests.

Results

In the past 4 weeks, 24.1% of older adults surveyed attended a live arts performance, 17.1% went to the movies, 11.6% attended an art exhibit and 23.4% created or performed art themselves. Rating the statement "There are plenty of opportunities for me to take part in arts and cultural activities in my neighborhood or community," 31.7% strongly agreed, 49.6% somewhat agreed, 14.7% somewhat disagreed and 3.9% strongly disagreed. Anxiety levels did not differ significantly between those who attended a live performance in the past 4 weeks and those who did not (ns). Anxiety levels also did not significantly differ based on whether respondents attended the movies or an art exhibit in the past 4 weeks. However, those who reported creating or performing art themselves in the last 4 weeks were more likely to say they felt "not at all" nervous, anxious or on edge vs. those who did not (50.3% vs 42.9%, $p < .001$). Those who strongly agreed there were art opportunities in the community were also more likely to say they were "not at all" anxious (57.1% vs. 48.8% for moderately agree, 38.5% for moderately disagree and 38.6% for strongly disagree, comparisons between agree and disagree groups $p < .05$).

Conclusions

Although passive consumption of arts through attending events, movies or art exhibits was not associated with lower anxiety for older adults, active production of art in the past 4 weeks had a significant benefit. Believing they had adequate art opportunities in their communities also correlated with lower anxiety levels. The findings suggest that active arts participation may have positive psychological effects on older adults and should be considered when evaluating community arts policy and programs.

C153 Student Presentation

Vaccine Status of Older Adults and Trust in Federal Institutions

C. Kricorian, K. Turner. *Research, For Good Measure, Simi Valley, CA, CA.*

Background

Vaccines have saved hundreds of millions of lives, yet COVID-19 vaccination became highly politicized during the pandemic, with ideologically-correlated concerns emerging about the safety of mRNA and viral vector platforms. In contrast, established vaccines for influenza and RSV—using live attenuated, inactivated, or recombinant protein technologies—have decades-long safety records. Recent questioning of vaccine benefits by federal officials may create public health concerns, particularly for older adults who face heightened vulnerability to vaccine-preventable diseases.

Methodology

We analyzed data from the February 2025 wave of the U.S. Census Bureau's Household Trends & Outlook Pulse Survey (HTOPS), which included 2,039 respondents aged 65 and older. The survey assessed

current vaccination status for COVID-19, influenza, and RSV, as well as confidence levels in government institutions.

Results

Among older adults surveyed, 38.1% reported receiving a COVID-19 vaccine and 43.5% a flu vaccine since August 2024, while 24.9% reported ever receiving an RSV vaccine. Confidence in the military did not differ between vaccinated and unvaccinated groups for any of the three vaccines. However, confidence in the police, Supreme Court, presidency, and Congress was significantly lower among those who received any of the three vaccines compared to unvaccinated individuals ($p < .01$ for all 12 comparisons). Effect sizes were substantial: among flu vaccine recipients, 64.5% reported “very little” confidence in the presidency versus 44.5% of non-recipients. Conversely, unvaccinated individuals expressed significantly less confidence in public schools and the criminal justice system than those who received COVID-19, flu or RSV vaccinations ($p < .01$ for all 6 comparisons).

Conclusions

The findings reveal a counterintuitive relationship: lower trust in most federal institutions was associated with higher vaccination rates, suggesting that trust in institutions like the presidency may paradoxically correlate with vaccine avoidance. This pattern likely reflects the politicization of vaccination and the institutional validation of anti-vaccine messaging in the post-pandemic period. Political alignment appears to shape both institutional trust and health behaviors. Without effective cross-partisan public health messaging, older adults remain at increased risk for vaccine-preventable illnesses as anti-vaccination sentiments persist in the political mainstream.

C154 Student Presentation

Technology-Enabled Dementia Care in Medicare Accountable Care Organizations: The Emergence of a Home-Stabilization Industry

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Dementia care is becoming a defined line of business in Medicare accountable care organizations (ACOs). In legacy fee-for-service Medicare, acute events such as falls, delirium, malnutrition, uncontrolled agitation, or caregiver collapse resulted in ED visits, hospital admissions, post-acute rehabilitation, and—in many cases—premature institutionalization. Under downside-risk total-cost-of-care arrangements such as ACO REACH, those same events are now cost liabilities rather than revenue generators. ACOs therefore benefit financially by preventing crises before they require high-cost interventions (Centers for Medicare & Medicaid Services [CMS], 2025a, 2025b). This economic reversal has elevated dementia care—historically fragmented, emotionally demanding, and financially unattractive—into a national strategic priority.

This paper argues that “technology-enabled dementia stabilization in the home” is no longer a loose collection of pilots. It is maturing into an industry with recognizable buyers (risk-bearing provider organizations, including ACOs), suppliers (remote patient monitoring [RPM] platforms, fall-risk wearables, caregiver telehealth vendors, home-based medical teams, nutrition and social-support partners), and regulators (CMS, along with agencies driving equity and social determinants of health expectations). The core product of this sector is not memory assessment or cognitive screening. It is continuous home stabilization: early detection of functional or behavioral instability, rapid tele-triage by specialized clinicians, in-home medical response when needed, and deployment of social supports such as meals, transportation, and respite, all documented as cost-avoidance events rather than “soft” add-ons (Levine et al., 2020; Berkowitz et al., 2019; Hager et al., 2022; Zhu et al., 2024).

Drawing on clinical trials of hospital-at-home and home-based primary care, systematic reviews of caregiver telehealth, observational studies linking medically tailored meals to reduced utilization, national ED utilization data for beneficiaries with Alzheimer’s disease

and related dementias (ADRD), and CMS policy frameworks around health equity and accountable care, this analysis maps the industry’s structure, economics, operational model, and barriers to scale (Alzheimer’s Association, 2024; Bowman et al., 2024; CMS, 2020, 2022, 2025a, 2025b, 2025c; Graven et al., 2021; Kruse et al., 2017).

C155 Student Presentation

An Automated Approach to Reducing Review Burden for Safety Monitoring in Deprescribing Studies

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Background: Safety monitoring of deprescribing studies can contribute to evidence about Adverse Drug Withdrawal Events (ADWE). Large sample sizes are needed to identify possible ADWE because they are often multifactorial and may be uncommon. Identifying ADWE requires manual record review and is labor intensive. We have developed a data-based approach to assess possible ADWE and applied it to an existing cohort to estimate possible ADWE in the context of safety monitoring.

Methods: Secondary analysis of the OPTIMIZE cluster pragmatic trial of deprescribing education (N=3,012). Participants were age 65+, 2+ chronic conditions including cognitive impairment. We applied a text- and discrete-data based algorithm to identify records with both a likely medication discontinuation (D/C) and a potential ADWE to five medication groups: oral hypoglycemics, statins, antithrombotics, bladder antimuscarinics, and antihypertensives. Discontinuations were based on text search and pharmacy order data, and potential ADWE were based on discrete data of diagnosis and procedure codes plus selected clinical parameters (e.g., blood pressure).

Results: For each medication group, the records with potential ADWE requiring manual review relative to the number of individuals taking the medication of interest at trial onset was as follows: Diabetes 10 potential ADWE out of 772 medication users; statins 52/ 2,377; Bladder antimuscarinics 13/ 212; antihypertensives 36/ 2,621; antithrombotics 13/ 931. For comparison, the data safety monitoring process of the OPTIMIZE clinical trial required 522 record reviews by pharmacists and geriatricians.

Conclusions: An algorithmic approach based on text search plus discrete data, can markedly reduce the number of manual record reviews required to estimate ADWE in deprescribing interventions. ADWE definitions are specific to drug groups and must be pilot tested and modified to reach an acceptable level of precision.

C156 Student Presentation

Use of food assistance programs among low-income homebound older adults

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Nearly 47 million older adults faced food insecurity in the United States in 2023. Many food assistance programs work to attenuate this ongoing challenge among low-income and older adults, yet there is little national data on program usage among homebound older adults and dementia populations, who disproportionately experience food insecurity.

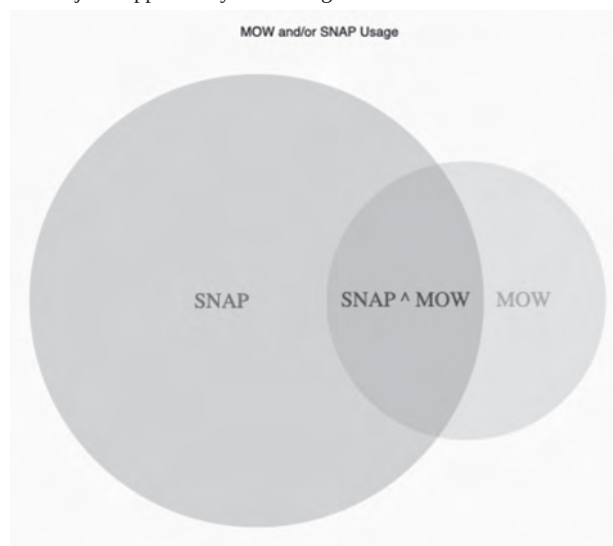
This study investigated the use of Meals on Wheels (MOW) and the Supplemental Nutrition Assistance Program (SNAP) among low-income, community-dwelling homebound older adults (unweighted N=888) by dementia status using the National Health and Aging Trends Study (NHATS) Round 13 (2023) data. We conducted descriptive statistics and bivariate analysis (e.g., Chi-square tests), applying survey weights to create population estimates.

Among the 3 million low-income homebound older adults, 25.8% were male, 42.0% were non-Hispanic White, 28.0% had probable dementia, and 29.0% experienced food insecurity. We found 60.8% reported food assistance programs usage (MOW and/or SNAP), including 40.8% who used SNAP only, 9.4% who used MOW only, and 9.8% who used both MOW and SNAP. There was no statistically significant association between dementia status and receipt of food assistance ($p=0.643$).

This study highlights a shortcoming in the use of MOW compared to SNAP in this vulnerable population suggesting a need to increase access for low-income homebound older adults.

Figure 1. Venn Diagram

Project supported by MSTAR grant 2T35AG026758-16.



C157 Student Presentation

When Social Support is Not Enough: Moderating Role of Coworker and Supervisor Support Differs Between Nursing Home Settings

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Background: Workplace violence (WPV), defined as instances in which an employee is assaulted or threatened at the workplace, is a common experience among certified nursing assistants (CNAs) working in nursing homes. Many CNAs view WPV as an inevitable part of their jobs and report a lack of support. While experiencing WPV is associated with increased burnout and poor mental health outcomes, support from supervisors and coworkers help CNAs cope. CNAs working in specialized memory units are especially at risk for WPV and experience more acts of violence than other CNAs. It is unclear if the positive effects of supervisor and coworker support generalize to CNAs working in memory care. Thus, the present study aimed to investigate the role of supervisor and coworker support in moderating WPV-related burnout both for CNAs working in memory care and non-memory care settings. **Method:** CNAs ($n = 287$) from nursing homes across Wyoming were administered surveys assessing factors related to occupational satisfaction and well-being. The sample was majority White (83.3%), non-Hispanic (84.7%) and cisgender women (80.5%) with 6.32 ($SD = 7.6$) years of experience as a CNA on average. Four moderation analyses were conducted to separately examine the impact of social support in memory care ($n = 163$) and non-memory care ($n = 124$) CNA groups. Each model included WPV (Workplace Violence Questionnaire) as a predictor, burnout (ProQOL Health) an outcome, and coworker/supervisor support (Leiden Quality of Work Questionnaire) as a moderator. **Results:** Results revealed

that coworker support moderates the relationship between WPV and burnout specifically among non-memory care CNAs ($\beta = .18$, $t = 2.43$, $p = .017$), with the model accounting for 37% of the variability in burnout ($R^2 = .37$), but it was not a moderator for memory care CNAs. Supervisor support was not a significant moderator in either group. **Conclusion:** Findings suggest that increasing support among coworkers may be an effective intervention for WPV-related burnout in CNAs not working in memory care. Of note, coworker support may not similarly benefit memory care CNAs, possibly due to increased exposure to WPV. Future research should examine the direction and causality of this relationship.

C158 Student Presentation

Associations between social determinants and arthritis multimorbidity

N. You, W. Zhang. *Emory University, Tucker, GA.*

Background: Aging with arthritis multimorbidity needs more research because arthritis is the most prevalent disabling and discordant condition, and functional limitations, healthcare utilization, cost, and mortality escalate with multimorbidity. Social determinants contribute to arthritis or multimorbidity, but their combined influence on multimorbidity in arthritis remains unexplored. Thus, this study aims to examine how social determinants contribute to increased multimorbidity in people diagnosed with arthritis.

Methods: We used the NeLL electronic health record database, a 17% random sample of Emory Healthcare patients from January 2012 to August 2019. We included 10,2040 adults diagnosed with osteoarthritis or rheumatoid arthritis. Annual Charlson Comorbidity Index (CCI) scores were calculated. Generalized estimating equation (GEE) models examined the associations between CCI scores and social determinants, including age, sex, race/ethnicity, and marital status.

Results: Of 102,040 adults, the median age was 61 years (IQR: 51–70); 64% were female; 58% were Non-Hispanic White and 36% were Black. Older age was significantly associated with higher comorbidity burden ($RR = 1.02$; $p < 0.001$). Female patients had significantly lower comorbidity than males ($RR = 0.80$; $p < 0.001$). Compared with Non-Hispanic White, Black patients showed the highest comorbidity burden ($RR = 1.46$; $p < 0.001$), followed by Hispanic Whites ($RR = 1.18$; $p < 0.001$). Marital status was also associated with comorbidity, with divorced ($RR = 1.23$; $p < 0.001$), separated ($RR = 1.41$; $p < 0.001$), single ($RR = 1.25$; $p < 0.001$), and widowed ($RR = 1.27$; $p < 0.001$) persons showing higher comorbidity scores than married individuals.

Conclusion: Among adults aging with arthritis, multimorbidity increased significantly with age and varied across demographic groups. Black patients had higher CCI scores, while females had lower multimorbidity than males. Multimorbidity among unmarried patients was also significantly higher than married patients. These findings highlighted important multimorbidity disparities among arthritis individuals and suggested that social and demographic factors play a meaningful role in shaping multimorbidity burden. By identifying groups at higher risk, we can provide evidence to support targeted intervention and healthcare resource allocation for the underserved patients.

C159 Student Presentation

The unmet needs of rural caregivers: A care management perspective

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Background: Rural caregivers of older adults have unique caregiving experiences related to ecological factors, including increased travel distance to the care recipient and lack of supportive networks and resources. Understanding the unmet needs of rural caregivers is necessary to prevent caregiver burnout and poor health outcomes. We conducted a

survey examining how caregiver needs differ between rural and urban caregivers from the perspective of care managers (CM).

Methods: A convenience sample of CM (e.g., social workers, nurse navigators) completed a survey designed by social workers and physicians working in geriatrics. The survey included both multiple choice and optional free response components. Recruitment occurred via emails and word of mouth from March to June 2025. Participants were included if >50% of the survey was completed, they provided their zip code for geographical designation, and worked in North Carolina. Free response answers were reviewed and inductively coded by two team members. This was an exempt study by the UNC Institutional Review Board.

Results: There was an initial 17% participation rate (66/387 potential participants) before removing those not meeting study criteria. Of n=36 participants, 98% of surveys were >50% completed. Most participants were ages 25-34 (38.9%), had a master's degree (55.6%), had practiced for 1-5 years (52.8%), and currently practiced in a rural area (50%). There were 89 responses to the optional free response questions. Two major themes emerged with subthemes: **Theme 1: Fewer resources for caregivers in rural versus urban communities;** *Sub-theme: unmet needs related to social determinants of health (transportation, travel distances for healthcare, food access, resource funding, social support);* **Theme 2: Barriers to helping caregivers in rural communities given limited resources;** *Sub-theme: Limited time and external pressures.*

Conclusions: Rural caregivers experience unique challenges, as do the CM trying to assist them. When CM encounter unmet needs related to social determinants of health, a dearth of resources can mean CM must spend more time helping caregivers access the limited resources available. This work is hypothesis-generating for expanding the survey to different rural areas and interventions to provide system-level support for caregivers and CM alike.

C160 Student Presentation

Association between interhospital transfer, readmission and inpatient mortality among older adults

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Background: Interhospital transfer (IHT) is a key strategy for providing access to specialty care; however, it is associated with adverse outcomes (prolonged length of stay, increased risk of inpatient mortality, and reduced rates of discharge home), particularly among older adults. We hypothesized that older IHT patients would have a higher rate of acute-care hospital readmission.

Methods: We used the 2019 National Readmissions Database to identify older adults who had and had not undergone IHT. Patients aged <65, December admissions, and same-day stays with multiple discharges or hospitalizations were excluded. Preliminary comparisons were made with the Rao-Scott Chi-Square test, while full analysis was made with logistic regression stratified by region, clustered by hospital and weighted by individual.

Results: Of the 11,836,556 older adults included in analysis, 0.9% (n=111,563) experienced IHT. Transferred and non-transferred older adults had similar age, quartile of median zip code income, and insurance. A higher proportion of transferees were male (53.5% vs. 46.4%) and from rural/micropolitan areas (29.5% vs. 17.8%). Cardiovascular disease was the most common major diagnostic category when first admitted among transferees (39.7% vs. 21.5%); transferees were also more likely to be admitted to a surgical service (37.9% vs. 26.3%). All comparisons are p<0.0001. Transferees were less likely than non-transferees to be discharged home and more likely to be discharged to a facility (33.9% vs. 27.4%). Median hospital length of stay at first admission was longer among transferees

(8.5 days [IQR 4.9-14.2] vs. 3.0 days [IQR 1.5-5.5]). There were 21.9% of transferees readmitted at least once within a year (vs. 19.5% of non-transferred); 9.3% were admitted ≥2 times (vs. 7.3% of non-transferred). After adjusting for confounders including mortality risk, risk of readmission, admitting service, insurer, procedure characteristics and others, IHT was associated with increased readmission rates (AOR 1.10, 95% CI 1.01-1.18), and with increased risk of in-hospital mortality (AOR 1.87, 1.76-1.98).

Conclusion: IHT is associated with increased readmission risk for older adults. These findings add to a burgeoning evidence base suggesting that IHT is associated with many long-term risks to older adults.

C161 Student Presentation

A Global Framework to Assess Long-Term Care System Design and Its Association With Care Utilization

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Background:

Long-term care (LTC) systems vary widely across countries, yet no validated framework exists to compare system design—especially in middle- and low-income settings—or to link system characteristics with individual care use. We developed a multi-domain LTC system assessment tool and examined how system features shape care utilization.

Methods:

We constructed a WHO-aligned framework measuring six domains: governance, financing, information/monitoring/evaluation (IME), workforce, service delivery, and innovation/research. System-level indicators were compiled for 17 countries across six world regions. Individual-level data (N=7,450 adults aged ≥65 years) came from the 2017–2019 Health and Retirement Study International Family dataset. Cluster analysis identified system typologies. Two-level logistic regression with country random intercepts assessed associations between system design and formal and informal care use.

Results:

Three system profiles emerged: high-development (n=8), medium-development (n=5), and low-development (n=4), primarily differentiated by governance, financing, and IME capacity. Country-level factors explained considerably more variance in formal than informal care (service delivery ICC: 0.045–0.06). At the individual level, living in systems with nationwide public financing (OR=8.7, p<0.001), universal eligibility (OR=5.5, p<0.001), or standardized assessment (OR=2.5, p<0.05) was strongly associated with higher formal care use. Informal care was related to universal eligibility (OR=0.35, p<0.01), mixed care settings (OR=5.14, p<0.05), and research funding (OR=2.25, p<0.01), though overall system effects were modest. Sensitivity analyses were consistent.

Conclusions:

This study provides the first validated global framework linking LTC system design with individual-level care use. High-impact policy levers—nationwide financing, universal eligibility, strong governance, and standardized assessment—substantially increase formal care access. Informal care remains largely individual-driven, underscoring the need for caregiver-support policies.

C162 Student Presentation

Global Rural–Urban Care Inequalities: How Long-Term Care System Design Shapes Disparities

S. Yang, S. Wang. Vanke School of Public Health, Tsinghua University, Beijing, China.

Background:

Rural–urban disparities in long-term care (LTC) access are widely reported, yet evidence is concentrated in high-income settings and rarely examines system-level determinants. We assessed global patterns of rural–urban differences in care use and evaluated how LTC system design contributes to these disparities.

Methods:

We analyzed 2017–2019 Health and Retirement Study International Family data from community-dwelling adults aged ≥ 65 years across 17 countries in six world regions. Care receipt (formal and informal) and care intensity were assessed. Logistic regression models adjusted for individual characteristics quantified rural–urban disparities; two-level hierarchical models evaluated the influence of country-level LTC system characteristics.

Results:

Rural older adults had lower assets, worse functional status, and more co-residence, whereas urban adults had higher chronic disease prevalence (all $p < 0.001$). After adjustment, rural residents had higher odds of receiving informal care (OR=1.39, $p < 0.01$) and lower odds of receiving formal care (OR=0.69, $p < 0.001$). Care intensity showed no significant rural–urban differences. Compared with Asian countries, all other regions had substantially higher formal care use (e.g., Western Europe OR=37.05; Northern Europe OR=27.42; all $p < 0.001$) and higher informal care intensity (OR range 1.92–6.70). Disparities persisted after accounting for LTC system characteristics (informal care OR=1.04, $p < 0.05$; formal care OR=0.76, $p < 0.01$).

Conclusions:

A substitution pattern between informal and formal care exists in rural areas worldwide. Rural–urban disparities are driven largely by uneven LTC system development rather than demographic or cultural differences. Strengthening LTC infrastructure, including transportation support and equitable system investment, may reduce global care access inequities.

C163 Student Presentation

Strengthening Geriatric Capacity in Ontario's Health Workforce: Results of a Provincial Training Needs Assessment to Support Specialized Geriatric Services

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Background: The growth of Ontario's older adult population living with frailty continues to outpace the health system's capacity to meet their needs. Inconsistent geriatric content in core professional training programs and limited access to continuing professional development (CPD) further complicate clinician shortages. To inform workforce planning and guide development of CPD, we conducted a province-wide Training Needs Assessment (TNA) in collaboration with Regional Geriatric Programs and Provincial Geriatrics Leadership Ontario. This study aimed to understand the current state of geriatric competence among clinicians, identify and prioritize learning and training needs, and guide strategies for capacity building within the health system.

Methods: Online surveys were distributed across Ontario (November 2021 - April 2022) targeting clinicians working in specialized geriatric services (SGS), and non-SGS healthcare providers who regularly care for older adults. Surveys captured demographics, qualifications, self-assessment of competence (5-point Likert scale) against the *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*, as well as CPD priorities. Data were analyzed using SPSS and inductive thematic analysis.

Results: 203 clinicians (SGS $n=107$; non-SGS $n=96$) participated, representing all health regions and various health professions. SGS clinicians reported higher self-rated competence ($MEAN=3.9$) across all domains than non-SGS providers ($MEAN=3.6$). Highest-rated competencies included person-centred care and interprofessional collaboration, while the lowest were in ethical decision-making, risk assessment for elder abuse, and mediating family conflict. Knowledge gaps included delirium identification, geriatric pharmacology, and mental-health and addictions care. Skills gaps included communication, shared decision-making, and management of BPSD. Both groups

identified experiential learning opportunities to build practical skills, and strong motivation for CPD ($MEAN=3.8$).

Conclusion: Findings reveal variation and gaps in geriatric competence, and the urgent need for structured CPD, mentorship, and training frameworks to build capacity. Findings offer a scalable approach for other health systems facing similar workforce challenges in caring for frail, aging populations.

C164 Student Presentation

Disparities in Outpatient Palliative Care: Sociodemographic and Clinical Predictors of Use and Survival in Older Adults with Cancer

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Background: Palliative care (PC) improves quality of life and aligns care with patient goals. Despite the proven benefits, utilization remains low, disparities persist, and little is known about use among older adults. This study aims to identify predictors of PC use and survival among older adults with cancer.

Methods: A retrospective cohort study was conducted among adults aged ≥ 65 seen at a comprehensive cancer center between January 2016 and June 2022. Descriptive statistics compared patients who did and did not complete outpatient PC visits. Logistic regression assessed predictors of completion of at least one PC visit. Cox proportional hazards modeling evaluated predictors of survival. Control variables included age at diagnosis, sex, race/ethnicity, cancer type, SEER stage, insurance status, prescription count, and baseline Karnofsky Performance Status.

Results: There were 2317 patients (57% male, 83% White, 89% Medicare) in the sample. Despite 21% of patients having regional/distant disease, only 11% received PC. In the adjusted models, male (aOR: 0.68, 95% CI: 0.51, 0.90) and functionally dependent (aOR: 0.32, 95% CI: 0.16, 0.63) patients were less likely to receive PC. Prescription count was associated with PC receipt (aOR: 1.07, 95% CI: 1.06, 1.09). No statistically significant disparities were observed across racial/ethnic groups in PC receipt. Older age (HR: 1.02, 95% CI: 1.01, 1.02), and receipt of PC (HR: 1.26, 95% CI: 1.08, 1.47) were associated with higher mortality risk, while White (HR: 0.82, 95% CI: 0.69, 0.98) and "Other" (HR: 0.70, 95% CI: 0.55, 0.89) patients had lower mortality risk compared to Black patients.

Conclusions: Outpatient PC remains underutilized among older adults with cancer. Although no racial disparities in PC receipt were observed, Black race was associated with worse survival. These findings highlight opportunities to implement institutional strategies such as expanded outpatient access and equity-focused quality improvement to ensure equitable PC for older adults.

C165 Student Presentation

Examining Social Connectedness and Racial Disparities in Fall Risk Among Older Cancer Survivors

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Falls are highly prevalent among older adults, especially those with cancer, due to treatment effects, multimorbidity, and declines in physical function. Additionally, social connectedness (social support, social network, contact frequency and social participation) are linked to falls; however, little is known about how these factors relate to fall risk among older adults with cancer survivors.

The data were drawn from the Health and Retirement Study (HRS) from 2008 to 2022 with the baseline sample of 1,109 cancer survivors 65+. The outcome measure was the biennial number of falls, and exposures included social connectedness (emotional social support, number of family members and social participation and volunteering). Negative binomial regression using longitudinal data were conducted to examine relationships between the exposures and number of fall outcome.

Results found that for cancer survivors who experienced fall risk, a baseline prevalence of fall was 38%, the mean age was 74.53 years, with 55.82% female and 86.46% non-Hispanic White. Compared to Whites, Non-Hispanic Black individuals had lower fall risk (IRR: 0.72, 95%CI: 0.52, 0.99). Having more family members (IRR: 0.98, 95% CI: 0.97, 1.00) and receiving more emotional support from family (IRR: 0.95, 95% CI: 0.91, 1.00) were associated with a reduced the rates of experiencing fall. Furthermore, greater frequent social engagement was associated with lower rates of fall risk for both Whites and Blacks.

In conclusion, stronger family involvement and emotional support appear to protect cancer survivors from fall risk. These findings highlight the importance of social support among different racial and ethnic groups in fall prevention and point to the need for targeted interventions to reduce fall risk among aging cancer survivors.

C166 Student Presentation

Clinical and Biomarker-Based Mortality Indices as Predictors of Delirium Risk and Severity

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Background: Delirium is associated with increased risk of mortality and adverse outcomes. While chronological age is a known risk factor, overall health status may better predict delirium vulnerability. We evaluated whether mortality risk indices, which provide composite measures of health status, predict delirium occurrence and severity independent of age.

Methods: We evaluated four mortality risk indices in two cohorts: hip fracture patients (n = 43, median age 78 years, Interquartile Range (IQR) 12.5) and hospital medicine patients (n = 54, median age 76.0 years, IQR 10.8). Three clinical indices (Modified Frailty Index, Lee Index, Walter Index) and one biological age index (PhenoAge) were calculated using admission data. Regression models measured associations between each index and either delirium prevalence or delirium severity measured prospectively during hospitalization using Confusion Assessment Method (CAM) or CAM-S respectively.

Results: Mortality risk indices showed divergent associations with delirium across patient populations. In hip fracture patients, higher Modified Frailty Index (MFI) scores were associated with greater odds of delirium (OR = 1.9, p = 0.02) and greater delirium severity when controlled for age (β = 16.0, p < 0.001). Similarly, higher Lee Index scores showed a trend toward greater odds of delirium (OR = 1.3, p = 0.06) and were significantly associated with greater delirium severity (β = 0.72; p < 0.001), independent of age. There were no significant associations between delirium measures and either the Walter Index or PhenoAge in hip fracture patients. In contrast, among hospital medicine patients, higher Walter Index scores were associated with lower odds of delirium (OR = 0.74, p = 0.01) and lower delirium severity (β = -0.36, p = 0.007), even after controlling for age. No significant associations were found between delirium measures and either the MFI, Lee Index, or PhenoAge in medicine patients.

Conclusions: Certain mortality risk indices predicted delirium risk and severity independent of chronological age, but predictive utility varied by index and patient population. These findings suggest that factors associated with increased mortality risk may not uniformly predict increased delirium risk across clinical contexts, highlighting distinct pathophysiological pathways that warrant further investigation.

C167 Student Presentation

Goals of Care and Care at End of Life for Persons Living with Dementia

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Background: Advanced care planning (ACP) ensures patients receive care that corresponds with what matters most to them. For persons living with dementia (PLWD), ACP in collaboration with caregivers results in less emotional distress at end of life (EOL), fewer aggressive interventions, and greater use of hospice care. Despite this, PLWD are less likely to have documentation of goals of care (GOC) and may be less likely to receive goal-concordant care at end of life (EOL). We compared documentation of GOC and care received at EOL of PLWD to those without dementia (controls).

Methods: Retrospective review of random subset of 30 PLWD and 30 age/sex/race-matched controls, drawn from 3114 decedents from 2 pragmatic trials to increase GOC documentation conducted from 2018-2023. Measures included demographics, primary decision-makers; GOC/What Matters Most described by focus on quality of life (QoL) (e.g., aging in place, comfortable death, no invasive interventions); and quantity of life (e.g. all interventions available). EOL treatments described (e.g. MOLST, comfort measures (CMO), codes, intubation, etc.). Those with no GOC were excluded. Outcomes compared with chi square.

Results: 60 decedents included 30 PLWD and 30 controls: mean age 80.9; 63.3% female; 10 White, 10 Black/AA, 6 Asian, 2 Other/Multiracial; 5 LatinX. Primary decision-maker for EOL care for PLWD was more often family (n=23) vs. controls (n=15) (p<.04). GOC for PLWD were more likely to prioritize quantity of life than for controls, n=8 vs. n=2, and QOL was a priority for n=11 and n=14 respectively (p=.05).

About half of each group signed a MOLST form for DNR/DNI at EOL (PLWD=14, controls=14). Both groups received similar proportion of comfort measures (n=14 vs 9, p=.12) while controls received a wider range of interventions (n=11 vs. 4, p<.03). PLWD used more hospice, n=7 vs. n=1 and 9 vs. 15 died in hospital/ICU/ED. Location of death unknown for 14 in each group.

Conclusions: Decision-makers for GOC for PLWD were more often family, who were more likely to prioritize quantity of life than those without dementia. However, persons without dementia received more varied interventions at EOL. PLWD received comfort measures and utilized hospice more. Future work should include qualitative analysis of ACP for PLWD for a more complete picture of the complexity of GOC/EOL decision-making.

C168 Student Presentation, Encore Presentation

Dual Orexin Receptor Antagonists for Delirium Prevention: A Systematic Review and Meta-Analysis

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Background: Delirium and dementia are leading causes of cognitive impairment in older adults and have a complex and interconnected relationship. Delirium can exacerbate cognitive decline in dementia, but it is also an independent risk factor for the development of long-term cognitive impairment and new-onset dementia. Studies have not shown any medication to be effective for the prevention or treatment of delirium and often carry a high risk of adverse effects where the balance of benefits and harms is unclear in older adults and those with dementia. Dual orexin receptor antagonists (DORAs) have emerged as a new, potentially safer class of medications for the management

of delirium. We conducted a systematic review to assess the effect of DORAs on the prevention and treatment of delirium

Methods: We searched MEDLINE, EMBASE, and CENTRAL for primary studies from inception to August 28 2025 evaluating the use of DORAs for delirium prevention or treatment compared to non-users. Citation screening, data abstraction, risk of bias, and quality of evidence assessments were conducted in duplicate. Random-effects model meta-analyses were conducted.

Results: Three randomized controlled trials (345 participants) and 7 observational studies (2,653 participants) met inclusion criteria. In pooled meta-analysis, DORA use led to a statistically significant decrease in the incidence of delirium (OR 0.30, 95% CI 0.21-0.43). DORAs decreased the odds of delirium in both post-operative (OR 0.32, 95% CI 0.16-0.62) and intensive care unit patients (OR 0.28, 95% CI 0.18-0.45).

Discussion: The preventative effect of DORAs on delirium was consistently observed with different study designs (RCTs vs observational), clinical settings (post-operative vs. ICU), and DORA agents. The effect appears to be statistically significant and may represent an important intervention to reduce the impact of delirium on long-term cognitive impairment and decline. However, data on their use in older adults and patients living with dementia is limited.

Conclusion: DORAs appear to reduce the incidence of delirium in hospitalized patients, but further research is needed to evaluate their effects in older adults and those living with dementia.

C169 Student Presentation

Natural Disasters and Functional Health: A Study of US Adults Age 65+

C. Kricorian. *Research Intern, For Good Measure, Simi Valley, CA, CA.*

Background

Understanding the health effects of climate change becomes increasingly important as its impacts accelerate. A growing body of data illustrates that the consequences of climate change may disproportionately affect vulnerable groups. However, little research has investigated how factors caused by climate change, such as natural disasters, affect older individuals with impaired functioning. Nationally representative survey data were analyzed to explore these effects.

Methodology

Data were analyzed from the February 2025 wave of the U.S. Census Bureau's Household Trends & Outlook Pulse Survey (HTOPS). The survey collected data on N=6,740 adults, including N=2,039 people aged 65 and older. Variables measured in the survey included having experienced a natural disaster within the past year and the Washington Group Short Set on Functioning (WG-SS). The WG-SS focuses on 6 domains to assess functional health, including measures of seeing, hearing, and mobility. Data were analyzed using chi-square tests.

Results

Among older adults surveyed, 7.6% reported being affected by a natural disaster in the past year (e.g., hurricanes, fires, or floods); the vast majority of these individuals were not displaced from their homes. Those who had experienced a natural disaster were significantly less likely to have no difficulty seeing (63.2% vs. 70.3%, $p<.01$) or hearing (62.6% vs 67.5%, $p<.01$). However, those who experienced a natural disaster were more likely to have no difficulty walking or climbing stairs (63.9% vs. 58.6%, $p<.01$). Older individuals who experienced a natural disaster did not differ significantly from those who did not in terms of difficulty remembering or concentrating, doing self-care, or communicating (all ns).

Conclusions

A small but sizable percentage of older adults reported being affected by a natural disaster in the past year. Those impacted reported more difficulty seeing and hearing than those who were not impacted. The results highlight the additional challenges that older adults may

experience during a natural disaster, compounding the effects on this vulnerable population. The findings have implications for addressing the unique challenges posed by natural disasters on older individuals and may help inform programs to improve the lives of those with impaired functional health.

C170 Student Presentation

The Bidirectional Associations Between Stress and Sensory Loss

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Introduction:

While the relationship between psychological stress and vision or hearing loss was reported independently, whether stress affects vision and hearing through shared biological impact is largely unexplored. This study aims to systematically summarize current evidence on how stress contributes to visual and auditory dysfunction through shared mechanisms and to illustrate evidence-based interventions that may mitigate these effects.

Methods:

A literature review was conducted on publications from 1993 to 2025. Conditions examined included glaucoma, age-related macular degeneration (AMD), and sensorineural hearing loss (SNHL). Selected articles focused on stress-related mechanisms affecting vision or hearing in humans, and/or investigated the role of stress reduction modalities in these pathological vision and hearing conditions.

Results:

Chronic stress contributes to neurovascular dysregulation, increased oxidative damage, and immune imbalance, all of which are implicated and shared in the progression of visual and auditory diseases. Evidence suggests that stress may exacerbate glaucoma, AMD, and SNHL, while sensory impairment itself can amplify psychological stress, forming a detrimental feedback loop. Emerging data indicate that mindfulness-based stress reduction (MBSR) and other stress management interventions may reduce intraocular pressure, improve vascular perfusion, and alleviate tinnitus-related symptoms.

Discussion/Conclusion:

Psychological stress plays an important role in the progression of vision and hearing dysfunctions, possibly through shared mechanisms. Future research should focus on parallel longitudinal studies on vision and hearing loss to directly investigate these shared mechanisms of stress and assess the efficacy of stress-reduction therapies in preventing or slowing dual sensory decline. The possible bidirectional relationship between stress and sensory health highlights the need for integrated care models that combine medical management with behavioral interventions.

C171 Student Presentation

A pilot study of the NUSHU X sneaker to measure gait changes in Parkinson's disease

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Background: Gait disturbances in Parkinson's disease (PD) are difficult to adequately assess and treat but contribute greatly to morbidity and mortality. The NUSHU X sneaker (Magnes AG) allows for continuous gait data gathering, with vibrotactile stimuli serving as potential treatment for gait disturbances. This study aims to measure gait and response to vibrotactile stimuli provided by the NUSHU X sneaker in PD.

Methods: Ten participants with PD will be recruited in each category: early <4 years, moderate 4-7 years, advanced ≥ 8 years during this 18-week study, plus ten healthy controls. We are reporting the preliminary data on the first eight PD participants who have completed the Baseline visit. Pre-vibration assessments were taken in the MDS-UPDRS III, 10m walk test and Timed Up and Go (TUG) wearing the NUSHU X sneaker. Continuous gait analysis was recorded for 1 to 3 minutes. Then the “Swing Phase” vibrational mode was turned on and participants walked approximately 300m with continuous analysis.

Results: Three early, one moderate, and four advanced PD participants completed the Baseline visit with mean age 64.0 years, disease duration 8.6 years, MDS-UPDRS III score 38.1 and 10m walk test 0.8m/s. Mean pre-vibration TUG was 19.0s and increased to 20.3s with vibration. Change with vibration in continuous gait metrics: stride length +1.5% (SD=11.8, $p=0.9$), stride velocity -3.0% (SD=10.5, $p=0.2$), stride duration +5.3% (SD=12.3, $p=0.3$), swing-stance -0.2% (SD=14.4, $p=0.8$), strike angle +19.4% (SD=29.9, $p=0.4$), heel clearance +2.4% (SD=9.2, $p=0.6$). Changes in participant SD decreased across all measures except stride duration: stride length -18.6% (SD=26.0, $p=0.07$), stride velocity -17.9% (SD=26.2, $p=0.06$), stride duration +11.1% (SD=56.3, $p=0.6$), swing to stance -35.7% (SD=26.2, $p=0.2$), strike angle -10.0% (SD=14.5, $p=0.09$), heel clearance -31.0% (SD=20.4, $p=0.01$).

Conclusions: In these eight participants, stride length and duration, strike angle, and heel clearance increased on average with vibration, while swing-stance ratio and stride velocity decreased. SD decreased across all measures except stride duration, suggesting an increase in walking stability in the vibrational mode and potential for the NUSHU X sneaker to serve as gait therapy.

C172 Student Presentation

Psychosocial Interventions for Chronic Pain in Older Adults: Outcomes, Implementation, and Evidence Gaps

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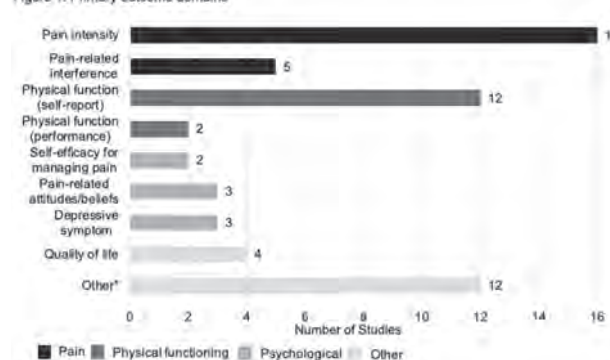
Background: Chronic non-cancer pain (CNCP) is disabling in older adults. Psychosocial interventions are promising nonpharmacologic options given polypharmacy risks, but evidence is fragmented.

Methods: We conducted a scoping review (Arksey & O'malley) with dual-reviewer screening using MEDLINE, Embase, the Cochrane Library, and PsycINFO (1/2000-8/2024). Eligible studies were randomized controlled trial (RCT), enrolled older adults (mean age ≥ 60) with CNCP and evaluated a psychosocial intervention. We summarized design, population, intervention, and outcome data.

Results: Of 7,394 studies, 49 met criteria. Samples were majority female (67%) and white (85%); 39% of studies did not report race/ethnicity. Trials most commonly evaluated cognitive-behavioral therapy (33%) or pain self-management (29%). Less frequent modalities were acceptance and Commitment Therapy (ACT) (4%), Emotional Awareness and Expression Therapy (EAET) (4%), mindfulness (14%), coping-skills training (6%), and positive affect-based (6%) interventions. Interventions averaged 13.5 (SD 10.8) hours over 9.6 (SD 7.5) weeks. Primary outcomes predominately targeted pain intensity and physical function, and few trials prioritized key psychosocial outcomes. Reporting was inconsistent for adherence (65%), credibility (20%), fidelity (30%), and harms (30%).

Conclusion: Understudied modalities warrant further evaluation in larger trials. Future trials should test brief, scalable models, diversify samples, and standardize outcomes—including psychosocial domains—with routine reporting of adherence, fidelity, and harms.

Figure 1. Primary outcome domains



C173 Student Presentation

Factors Associated with Self-Reported Cognitive Impairment in Long-term Breast Cancer Survivors

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Advances in breast cancer detection and treatment have increased the number of long-term survivors, turning attention towards lasting effects, including cancer-related cognitive impairment (CRCI). However, most work focuses on cognitive changes during or shortly after chemotherapy, leaving gaps in our understanding of CRCI. We describe the prevalence of self-reported CRCI in survivors up to 21 years post-treatment and examine associations with neurobehavioral symptoms, health behaviors, and quality of life.

In women ≥ 3 years post-treatment for stage I-III breast cancer, cognition was evaluated using the Functional Assessment of Cancer Therapy-Cognition (FACT-Cog; PCI scores <54 indicating CRCI). Neurobehavioral symptoms were assessed with PROMIS-Anxiety/Depression and Functional Assessment of Chronic Illness Therapy Fatigue (FACIT-F). Health behaviors were evaluated by the NHANES Health Behavior Questionnaire (HBQ) and quality of life with the Functional Assessment of Cancer Therapy-General (FACT-G). Associations with CRCI were analyzed utilizing modified Poisson multivariable regression models, adjusted for race and age.

Participants (N=215) averaged age 56 (SD 12) and 8 (SD 4) years post-diagnosis, with 37% reporting CRCI. All neurobehavioral symptoms were associated with cognition: 5-point increases in PROMIS-Anxiety (RR 1.29 (1.17, 1.42)) and PROMIS-Depression (RR 1.33 (1.21, 1.45)) were associated with increased risk for CRCI, while 5-point increases in FACIT-F (less fatigue) were associated with decreased risk (RR 0.77 (0.72, 0.81)). Walking ≥ 10 minutes 2x/week (RR 0.67 (0.46, 0.97)) and vigorous exercise ≥ 3 x/week (RR 0.62 (0.40, 0.94)) were associated with lower risk for CRCI, while having ≥ 1 fall in the prior 6 months increased risk (RR 1.63 (1.12, 2.38)). No associations were observed with smoking history, or alcohol use. Higher FACT-G scores, indicating better quality of life, were associated with decreased risk (RR 0.87 (0.83, 0.90) for a 5-point increase in FACT-G).

Many years after treatment, more than 1 in 3 survivors reported CRCI, which was highly associated with mental health symptoms, fatigue, and physical activity. Future work should investigate these modifiable factors as potential intervention targets to support cognitive health throughout survivorship.

C174 Student Presentation

The effects of meditation-based interventions on sleep quality among adults ≥55 years with mild cognitive impairment: a systematic review

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Background: Sleep disturbances are common among older adults with mild cognitive impairment (MCI), linked to cognitive decline and reduced quality of life. Pharmacological treatment remains prevalent despite safety concerns such as falls, delirium, and cognitive worsening. Meditation-based interventions (MBIs) may improve sleep and psychological well-being, yet evidence in MCI populations remains limited and heterogeneous. This systematic review evaluated the effectiveness of MBIs on sleep quality among adults ≥55 years with MCI and identified implications for gerontological nursing practice.

Methods: Following PRISMA 2020 guidelines, five databases (PubMed, PsycINFO, Embase, CINAHL, and Google Scholar) were searched through June 2025. Eligible studies included randomized controlled trials (RCTs), pilot RCTs, and quasi-experimental designs targeting adults ≥55 years with MCI. Studies were required to use validated sleep measures (PSQI, ISI, AIS, ESS, actigraphy, EEG). Risk of bias was assessed using RoB 2.0 and ROBINS-I, and certainty of evidence using GRADE. A narrative synthesis was conducted due to heterogeneity in intervention types, duration, and outcomes.

Results: Seven studies (n = 434) met inclusion criteria. Interventions lasted 4–12 weeks and included mindfulness, mantra, sound meditation, and hybrid. Five studies demonstrated significant improvements in subjective sleep quality; one actigraphy-based study reported reduced daytime napping, and one showed short-term benefits that were not maintained at follow-up. Longer duration and greater adherence yielded stronger effects. Secondary outcomes included reduced anxiety, stress, and depression, and improved attention and memory. Overall, evidence indicated moderate certainty that MBIs may improve subjective sleep quality in MCI.

Conclusions: Current evidence suggests MBIs show promise in improving subjective sleep quality and psychological well-being among adults ≥55 years with MCI. Integrating meditation-based strategies could be explored as a potential, supportive approach within gerontological nursing and community programs; however, caution is warranted given limited and heterogeneous evidence. Future research should include large, multi-site RCTs with standardized protocols, both objective and subjective sleep assessments, and diverse populations to strengthen generalizability and guide evidence-based practice.

C175 Student Presentation

The Structure and Quality of Social Networks and Cognitive Trajectories in Older Americans: A 10-Year Longitudinal Study

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Background:

Social networks may modify cognitive aging, yet most studies use limited measures and short follow-up. We examined how structural and functional network characteristics relate to long-term cognitive trajectories.

Methods:

We used 2012–2022 Health and Retirement Study data from adults aged ≥50 years. After excluding participants with severe baseline impairment, missing psychosocial measures, or <3 follow-ups, 10,105 remained (mean age 65.9; 60.4% female; 27% racial/ethnic minority). Cognitive function was assessed using the Langa–Weir system. Social network measures included structure (spouse, children, relatives, friends), contact frequency, support, and strain. Group-based trajectory modeling identified cognitive trajectories. Multinomial

logistic regression examined associations adjusting for demographics, lifestyle, and comorbidities.

Results:

Three trajectories were identified: high (31.3%), middle (49.0%), and low (19.7%). The low group had more women, racial/ethnic minorities, lower education, and higher cardiometabolic burden. Higher network quality was associated with lower odds of belonging to the middle (RRR 0.89, 95% CI 0.83–0.96) and low (RRR 0.82, 95% CI 0.75–0.90) trajectories. More frequent social contact was protective (RRR 0.88, 95% CI 0.85–0.91). Network size and overall structure showed no significant associations. Spousal presence was strongly protective (RRR 0.07, 95% CI 0.02–0.22). Greater family support predicted better trajectories, whereas friend-related strain predicted worse trajectories. Sensitivity analyses were consistent.

Conclusions:

Functional aspects of social networks—quality and engagement—were more strongly associated with cognitive trajectories than structural size. Supportive spousal and family relationships were protective, whereas relational strain predicted decline. Enhancing positive social interactions may help preserve cognitive health in aging populations.

C176 Student Presentation

Beyond Delirium: Characterizing Post-Delirium Depression and Its Clinical Impact in Hospitalized Geriatric Patients

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Background: Delirium affects a large proportion of hospitalized older adults and is associated with substantial consequences. While cognitive decline after delirium has been well studied, depressive symptoms in the post-delirium period remain underdiagnosed. Emerging literature suggests that post-delirium depression contributes to poorer functional recovery, increased rehospitalization, and accelerated cognitive deterioration. Our objective is to identify post-delirium depression using the Geriatric Depression Scale (GDS) as a measure in hospitalized older adults and its clinical impact.

Methods: A literature review of peer-reviewed studies on depressive symptoms following delirium in hospitalized older adults was conducted, including case reports, clinical trials, clinical studies, RCTs, observational studies, controlled clinical trials, and cohort studies. Studies published in English within the last 10 years using GDS as measure were included; non-English studies, using PHQ-9 as measure, and systemic reviews were excluded. Common reported demographics included sex only, with delirium groups showing 45:32 male-to-female ratio and non-delirium groups 264:159. A descriptive analysis was used to compare findings across studies.

Results: Across studies, delirium was not associated with post-delirium depression based on GDS measures. In hospitalized settings, depression prevalence in older adults measured by GDS ranged from 7% in post-operative patients (de Mul) to 18% in geriatric inpatients (Weng) and 35% in the emergency room (Kilicaslan) when delirium was not considered. Depression itself demonstrated limited prognostic value compared with the stronger associations observed for delirium with functional decline and mortality.

Conclusion: Post-delirium depression is an underrecognized complication among older adults, with most literature studying depression and delirium separately. Current evidence supports the incorporation of depression and delirium screening and early intervention to improve functional outcome, yet psychiatric sequelae following delirium lack sufficient research. More prospective and randomized trials are needed to study geriatric delirium sequelae such as depression, along with consistent use of standardized geriatric measures such as GDS to characterize post-delirium depression.

C177 Student Presentation

Readability of Commonly Used Geriatric Depression Screening Measures

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Background: Depression is among the most common mental health disorders in older adulthood. Geriatric depression is often underdiagnosed and can subsequently lead to long term negative health outcomes. Accurate detection of depressive symptoms requires screening tools that measure symptoms of depression that are both psychometrically valid and easily understood by lay respondents. Readability, or the ease with which someone can understand a written material, ensures that screeners are comprehensible to older adults and that they accurately capture their symptom experience. Although the readability of some measures of depression have been examined, the readability of screeners that are commonly or specifically used in geriatric depression has not been assessed.

Methods: We included 6 measures frequently used to screen for geriatric depression (BDI-II, GDS-15, HADS-D, PHQ-9, QIDS-SR, Zung SDS). Readability was assessed via the Flesch-Kincaid Readability Tests (Kincaid et al., 1975), which provides: 1) an ease level, rated on a scale of 1-100, where 100 is the most readable, and 2) the appropriate US grade equivalency level for that text. All analyses were conducted in Microsoft Word, which has built-in software for these formulae.

Results: Readability analyses indicated that the average reading ease level across measures was 82.6 (SD=9.20) and the average grade level was 4.52 (SD=2.61). The ease levels ranged from 67.5 (PHQ-9) to 94.2 (Zung SDS), with corresponding estimated grade levels of 9.4 and 1.8. Half of the measures had an ease level between 80 to 90 which demonstrates a reading grade level between 3 to 4.1.

Conclusion: Our analyses indicate a wide range of variability in regard to the readability of screeners that are commonly used for geriatric depression. Notably, the PHQ-9 demonstrated the highest reading level despite being most commonly utilized in primary care settings, indicating a need to evaluate the accessibility of measures that are used to detect symptoms of depression. There are methodological limitations; future research should conduct multiple forms of readability analysis to account for modern reading abilities that may differ from those at the time readability formulas were developed, vocabulary difficulty, and respondent academic performance in reading as opposed to years of education completed (Schinka, 2012).

C178 Student Presentation

Modified Hospital Elder Life Program (m-HELP): Systematic Review and Meta-analysis of Effectiveness

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Background: Delirium is a complication where one has a sudden onset of change in mental function and is confused. Delirium causes reduced awareness of surroundings, reduced ability to focus, and cognitive decline, and can lead to long-term complications or death. The Hospital Elder Life Program (HELP) is a widely recognized evidence-based practice that aims to prevent the sudden onset of delirium for elderly patients in hospital settings. HELP uses a multicomponent, nonpharmacological approach with skilled staff and trained volunteers to provide interventions to reduce the rate of delirium. Modified Hospital Elder Life Program (m-HELP) is an altered version of HELP that uses modified versions of original HELP interventions and is being recently researched and utilized in hospitals.

Objective: To explore the effectiveness of modified Hospital Elder Life Program in terms of delirium status, fall incidence, and length of hospital stay on elderly patients in the hospital setting.

Method: Systematic review of m-HELP and HELP randomized controlled trial (RCT) studies of PubMed, CINAHL, Embase, Wiley Online Library, Google Scholar, and Cochrane Library from 2020 to 2025, using PRISMA and controlled keyword combinations.

Results: Of the six final articles included, five investigated the outcome of a modified or adapted version of HELP intervention in reducing delirium in a hospital setting. Of the five m-HELP articles, four measured delirium incidence, two articles measured fall incidence, two articles measured length of stay, and four articles included hospital readmission. In all, four studies showed a significant difference between the intervention group and control group in delirium incidence (intervention group 2.6 - 24.2, control group 16.98 - 41.7; p-value <.001 - .04). One article showed a lower fall incidence in the intervention group (intervention group 2.5, control group 4, p-value .694), however was not statistically significant. Two studies demonstrated a statistically significant difference in length of hospital stay between the groups, with a significant decrease in length of stay in the intervention group (intervention group 12.15 - 12.26, control group 16.03 - 16.41; p-value .000 - <.001).

Conclusion: Implementation of a modified Hospital Elder Life Program is potentially effective for decreasing delirium rates, including delirium incidence, length of hospital stay, and fall incidence.

C179 Student Presentation

Sociological Factors Influencing Grief In Caregivers of Persons Living With Dementia

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Background: Informal caregivers of Persons Living With Dementia (PLWD) are a group at increased risk of developing Prolonged Grief Disorder (PGD) compared to the general population. One of the strongest predictors of PGD is the severity of grief that individuals experience before the death of their loved one. It is well documented that caregivers of PLWD experience significant dementia-related grief before the death of the PLWD. While grief has traditionally been studied as a psychological process that individuals go through in response to loss, it is also inherently a sociological process because the bereaved individual loses an important social connection. This study aims to identify the sociological factors that contribute to more severe dementia-related grief in caregivers of PLWD to inform targets for future therapies with the end goal of preventing and/or lowering the caregiver's PGD symptom severity.

Methods: This cross-sectional analysis uses a battery of surveys measuring an array of sociological constructs collected from 69 informal caregivers of PLWD in the United States. Multivariate logistic regression was performed to identify which measures most strongly predicted that a caregiver would report syndrome-level dementia-related grief, defined by a score of greater than 30 on the Prolonged Grief-12 Scale.

Results: Approximately 25% of caregivers met the criteria for syndrome-level dementia-related grief. The two measures of social interactions that were significant predictors of syndrome-level dementia-related grief were the Relational Deprivation Scale (Adjusted Odds Ratio: 3.91, p = 0.018) and the Interpersonal Needs Questionnaire (Adjusted Odds Ratio: 3.24, p = 0.044).

Conclusions: The 25% of caregivers in this sample meeting the threshold for syndrome-level dementia-related grief underscores the fact that this is a group at an increased risk for PGD, as only 6-10% of the general bereaved population experiences PGD. These results also suggest that minimizing the losses the caregivers perceive in their relationship with the PLWD and providing additional social support to ensure caregivers experience feelings of belonging in their lives, should be areas of focus for future research on the treatment of PGD.

C180 Student Presentation

Comparative Risk of Falls and Emergency Department Visits with Suvorexant vs. Zolpidem in Insomnia Treatment

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Introduction

Insomnia is a common, often chronic, condition affecting approximately 10% of the adult population, with a higher prevalence among older adults, woman, and individuals with socioeconomic hardships.¹ Long-term treatment often requires pharmacological intervention, yet many hypnotics increase fall and hospitalization risk. This study compared falls and emergency department (ED) visits in older adults prescribed suvorexant or zolpidem.

Methods

A retrospective TriNetX analysis included adults ≥ 65 years with insomnia. Patients receiving suvorexant or zolpidem were propensity-matched to reduce confounding. Outcomes (falls and ED visits) were assessed from 30 days after the index prescription through 5 years using risk estimates, event counts, and Kaplan–Meier analysis.

Results

For ED visits, 8,929 suvorexant and 8,352 zolpidem users were analyzed. ED incidence was lower with suvorexant (19.0% vs 20.4%), with a risk difference of -0.015 ($p=0.0015$), risk ratio 0.928, and odds ratio 0.911. In 16,218 matched patients evaluating event counts, suvorexant users had fewer ED visits (3.09 vs 3.39, $p=0.001$). Kaplan–Meier curves showed higher ED-free survival at 5 years (68.17% vs 65.45%, $p<0.001$; HR 0.885).

For falls, 13,413 suvorexant and 13,064 zolpidem users were included. Suvorexant showed lower fall risk (risk ratio 0.919; odds ratio 0.911; $p=0.023$). Fall-free survival at 5 years also favored suvorexant (82.81% vs 80.64%, $p=0.001$; HR 0.876).

Conclusion

Across a large real-world cohort of older adults with insomnia, suvorexant was associated with fewer falls and ED visits and demonstrated higher event-free survival over five years. These findings suggest suvorexant may offer a safer pharmacologic option for geriatric insomnia. Further research should confirm long-term safety of orexin antagonists.

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C181 Student Presentation

Feasibility and Acceptability of a Virtual Mindfulness Intervention for Older Adult Veterans with Mild Cognitive Impairment

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Background: Mindfulness, the practice of awareness in the present moment, has been shown to improve cognition in older adults with Mild Cognitive Impairment (MCI). We examined the feasibility and acceptability of the first fully virtual mindfulness intervention for older adult veterans with MCI, called Mindfulness Approach for Veterans' Emotional and Neurological Wellness (MAVEN).

Methods: In this pilot study, nineteen older adult veterans with MCI ($M=78.4$ years, 95% male, MoCA 22 [IQR 19–25]) were

randomly assigned to receive immediate MAVEN ($n=8$) or receive MAVEN after a 10-week waitlist control ($n=11$). MAVEN consisted of a weekly virtual Mindfulness-Based Stress Reduction group class, and daily mindfulness practice delivered via the Happier Meditation application. Measures of self-rated trait mindfulness were captured pre- and post-MAVEN using the Multidimensional Assessment of Interoceptive Awareness (MAIA).

Results: Intervention completion rates were 100% in the immediate MAVEN condition (final $n=8$) and 36% in the waitlist control condition (final $n=4$). Dropouts were due to personal reasons (72%), technology issues (14%), or difficulty perceiving intervention benefit (14%). Immediate condition participants engaged in MAVEN substantially, with a median time of 2,184 minutes of combined class attendance and homework completion. Greater time spent engaging with MAVEN was correlated with pre- to post-intervention score increases on the Noticing subscale of MAIA, reflecting participants' improved awareness of bodily sensations ($N=8$, $r=.78$, $p=.023$). Assessment of waitlist control condition outcomes is underway.

Conclusions: MAVEN's fully virtual format is feasible to implement and acceptable to older adult veterans with MCI. Preliminary improvement in bodily awareness suggests potential for mindfulness-related cognitive changes. These findings support expansion of MAVEN to a fully powered trial.

C182 Student Presentation

Digital Education Platform Engagement Among Dementia Caregivers

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Background:

Digital educational platforms designed to support caregivers' dementia knowledge and well-being may improve caregiver burden and patient outcomes, but their effectiveness as an intervention remains limited in the literature.

Methods:

A retrospective cohort study was conducted among dementia patients enrolled in the GUIDE model who received a digital education platform (DEP) at the Center for Memory Loss and Brain Health. Information was collected on demographics, acceptance of Trualta (a DEP for caregiver support and education), FAST stage, Zarit, PHQ-9, FAQ, PROMIS, and MOCA. The number of ED visits, urgent/office visits, and hospitalizations within three months of each patient's platform sign-up date was assessed as a patient outcome. Caregiver outcomes were measured by the number of DEP engagements and pre- and post-caregiver surveys.

Results:

Among 58 patients who completed 3-month follow-up, 13 (22%) accepted DEP. Those who accepted were similar to non-acceptors in age (mean (SD): 83.8 (4.9) vs. 81.3 (8.2) years; $P=0.316$) and sex (23% vs. 38% male; $P=0.515$). The majority of acceptors were white (77%). After accepting DEP, 3 caregivers attended webinars, 5 attended online sessions, and all 13 participated in self-engagement. 8 of them had more than 12 engagements. 5 out of 13 caregivers completed pre- and post-surveys and reported positive feedback. Many who did not complete post-surveys still demonstrated substantial engagement, with activity counts ranging from 4 to 99, with an average of 15 per caregiver. Neither group had any ED visits or hospitalizations. The non-acceptor group had 1 urgent visit.

Conclusion:

According to our data, dementia caregivers reported 22% acceptance and a wide range of platform engagement, reflecting a broader trend: dementia caregivers are more likely to use digital educational and support tools. Acceptance of DEP is more prevalent in the white population. We had a low incidence of adverse patient

outcomes in both groups. These findings highlight the relevance of digital resources for improving caregivers' experiences with dementia patients and their potential benefits for remote and underserved areas. We also need to explore strategies to improve engagement among minority populations.

C183 Student Presentation

Clinical Characteristics and Mortality of Hospitalized Older Adults Receiving Physical or Chemical Restraints for Behavioral Symptoms

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Background: Behavioral symptoms are common among hospitalized older adults with delirium or dementia and can lead to physical or chemical restraint use. Restraint use for behavioral symptoms has known risks, but survival after use is poorly characterized. This study describes the clinical characteristics and mortality of older adults receiving restraints for behavioral symptoms on an Acute Care for Elders (ACE) unit.

Methods: We conducted a retrospective study of adults admitted to a 24-bed ACE unit who received as-needed physical (soft 2- or 4-point restraints, lap belts, or mitts) and/or chemical restraints (olanzapine, haloperidol, quetiapine, risperidone, or ziprasidone) for behavioral symptoms between January 2024 and August 2025. Patients on comfort measures or hospice were excluded. Demographic and clinical characteristics—including age, dementia history, restraint type, medication and route, prior antipsychotic use, and disposition—were extracted via structured chart review. Post-restraint survival was obtained from the electronic medical record. To contextualize restraint frequency, total ACE admissions and baseline unit characteristics were also reviewed. Descriptive statistics summarized clinical characteristics and mortality.

Results: During the study period, 1292 adults were admitted to the ACE unit (mean age 81.9 years; 37% with dementia), of whom 62 (5%) received restraints (mean age 82.8 ± 6.9 years; 77% with dementia). Physical restraints were used in 24% (n=9), chemical restraints in 85% (n=47), and both in 9.7% (n=6). Olanzapine (51.6%), haloperidol (22.6%), and quetiapine (22.6%) were the most common chemical restraints and were given orally (56.6%) more than intravenously/intramuscularly (41.5%). Before admission, 34.2% were prescribed an antipsychotic, while 23.7% were newly prescribed one at discharge. Mortality during the study period after restraint use was 27.4% (mean survival 73 days; median 22.5 days).

Conclusions: Hospitalized older adults restrained for behavioral symptoms were predominantly patients with dementia and had high short-term mortality. Future work should focus on reducing restraint use, clarifying the relationship between behavioral symptoms, restraint exposure, and outcomes using causal methods, and evaluating restraint use as a prognostic marker.

C184 Student Presentation, Encore Presentation

Use of Dual Orexin Receptor Antagonists for Insomnia and the Risk of Falls and Fractures: A Systematic Review and Meta-analysis

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Background: Falls are the leading cause of injury in older adults. Sedative-hypnotic use is a known risk factor, but their use continues to be common. Dual orexin receptor antagonists (DORAs) are a new, potentially safer class of medications for insomnia. Objective: We conducted a systematic review to assess the effect of DORAs on falls and fractures.

Methods: We systematically searched MEDLINE, EMBASE, and CENTRAL from inception to August 28 2025 for studies reporting falls and fractures in DORA users and non-users. We also examined gray literature. To qualify for inclusion, studies needed to meet the following criteria: 1) provided data on falls and/or fractures among participants using DORAs, and 2) were a randomized controlled trials (RCTs) or observational studies in any clinical setting. Scoping reviews, systematic reviews, meta-analyses, study protocols, and conference proceedings were excluded. Citation screening, full-text review, data abstraction and risk of bias assessment were conducted in duplicate, and disagreements were discussed and resolved by consensus. Random-effects model meta-analyses were conducted. The primary outcomes were the incidence or rates of falls and fractures among adults using DORAs compared to non-users.

Results: Nineteen studies (10 RCTs, 9 observational, 183,595 participants) met inclusion criteria. Based on the totality of evidence, DORA use did not increase the risk of falls compared to non-use (OR 0.76, 95% CI 0.56-1.04). RCT data suggests a reduction in fall risk (OR 0.59, 95% CI 0.35-0.98) not seen in observational studies (OR 0.88, 95% CI 0.59-1.31). No association was observed between DORAs and fractures (OR 1.05, 95% CI 0.94-1.18).

Conclusion: DORAs may reduce fall risk and be a safer alternative to other insomnia medications, but it is unclear whether these effects can be expected in the "real-world" setting. Additional studies are needed to meet the optimal information size (OIS) criterion. Low event rates and limited RCT data in older adults warrant cautious interpretation of results. Further research is needed to confirm their safety in older adults.

C185 Student Presentation

Arterial Stiffness and Carotid Wall Thickness Reflect Cerebrospinal Fluid Biomarkers in Preclinical Alzheimer's Disease

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Background: Vascular aging may contribute to Alzheimer's disease (AD), yet the clinical utility of vascular markers for identifying early AD pathology remains unclear. We aimed to determine whether noninvasive arterial stiffness and subclinical atherosclerosis measures are associated with cerebrospinal fluid (CSF) biomarkers of AD and whether these vascular markers discriminate preclinical AD.

Methods: We analyzed data from two longitudinal cohorts at Emory University, the Healthy Brain Study and B-SHARP. All participants underwent identical cognitive testing and CSF biomarker assessment using the Elecsys platform (Aβ42, total tau, pTau181). Vascular health was quantified via carotid-femoral pulse wave velocity (PWV, arterial stiffness), subendocardial viability ratio (SEVR), carotid intima-media thickness (CIMT), and digital reactive hyperemia (EndoPAT). Participants were categorized by cognitive and biomarker status as cognitively normal/biomarker-negative, preclinical AD, AD-type mild cognitive impairment (MCI), or non-AD MCI. Multivariable linear models and logistic regression (covariates: age, sex, race, education, BMI, hypertension, seated BP) were used to evaluate associations with CSF biomarkers and preclinical AD status. Discrimination was assessed using area under the receiver operating characteristic curves (AUC), bootstrap-corrected.

Results: We included 1,300 participants (mean age 63.3±7.2 years; 67% female; 20% Black) in the analysis. Higher PWV was independently associated with lower CSF Aβ42 (-10.7 pg/mL per 1 m/s; P=0.047). Higher CIMT correlated with higher tau (+50.0 pg/mL) and pTau181 (+4.9 pg/mL) per 0.1 mm increase (P≤0.009). SEVR showed inverse associations with tau species but not Aβ42. In adjusted logistic models, PWV modestly increased the odds of preclinical AD (OR 1.22; 95% CI 1.14-1.30), as did CIMT (OR 1.17 per 0.05 mm;

95% CI 1.05-1.31). Discrimination for preclinical AD was limited (AUC 0.63 for PWV; 0.57 for CIMT), comparable to seated blood pressure.

Conclusions: Arterial stiffness and carotid wall thickening are associated with AD-related CSF biomarker changes, supporting a link between vascular aging and AD pathology. Although their standalone diagnostic performance is modest, PWV and CIMT may serve as accessible risk indicators.

C186 Student Presentation

Physical Health and Sleep Quality as Mediators of the Stress-Cognitive Function Association in Community-Dwelling Older Adults

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Background:

Stress is a risk factor for impaired cognitive function, but the mechanisms linking stress and cognitive function in older adults remain unclear. Because stress influences several physiological and behavioral processes linked to cognitive aging, identifying the specific pathways through which it may contribute to cognitive function is essential. This study examined whether physical health and sleep quality mediate the relationship between stress and cognitive function in community-dwelling older adults.

Methods:

Data were analyzed from 600 adults aged 60 and older. Ordinary least squares regression models tested associations between stress, physical health, sleep quality, and cognitive function while adjusting for age, gender, race, and education. Bootstrapped mediation analyses were conducted to estimate indirect effects of physical health and sleep quality on the stress-cognition relationship.

Results:

Participants were community-dwelling older adults who showed the expected age-related pattern of modest stress levels, frequent sleep disturbances, and reduced physical functioning. Higher stress was associated with lower cognitive function ($\beta = -0.114$, $p = 0.002$). Both physical health (β indirect = -0.0277 , 95% CI [-0.0501 , -0.0086]) and sleep quality (β indirect = 0.0350 , 95% CI [0.0031 , 0.0694]) partially mediated this association. Older age, male gender, and lower educational attainment were also associated with poorer cognition.

Conclusions:

Stress may influence cognition partly through sleep and physical health, pointing to modifiable pathways for cognitive resilience in late life. Given their role in daily functioning, sleep quality and physical health offer reasonable pathways through which stress may influence cognitive performance in later life. This study adds to the literature by jointly evaluating physical health and sleep quality as mediators of the stress-cognition relationship in older adults, identifying both mediators as practical intervention targets that may help buffer the cognitive impact of stress in older adults.

C187 Student Presentation

Aligning Geriatric Intake Processes With the 4Ms Framework: A Qualitative Needs Assessment at an Academic Geriatrics Clinic

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Background: Patients in geriatric clinics present with interrelated medical, functional, cognitive, and social needs that require a structured intake process. The current form at the Home Instead Center for Successful Aging is not well suited to identifying factors that guide goals of care and is not organized around the 4Ms framework (What

Matters, Medications, Mentation, Mobility). This study assessed opportunities to redesign the form using a 4Ms-based structure.

Methods: We conducted a qualitative descriptive study in November 2025 at an academic geriatrics clinic. Participants included social workers ($n=2$), a nurse care coordinator ($n=1$), and medical providers ($n=4$). Interviews were completed in person with supplemental email feedback. Questions addressed missing information, needed revisions, and ways to embed the 4Ms. The current form was reviewed to contextualize responses. Themes were aggregated descriptively. Racial and ethnic data were not collected.

Results: Participants identified several elements to retain, including functional status, social assessment, hospitalization and surgical history, medication list, allergies, and major health concerns. The Review of Systems was viewed as low-value and the family history section as duplicative. Functional status should be expanded to include ADLs, IADLs, caregiver capacity, driving safety, living environment, and availability of support. Participants recommended adding a structured What Matters section with brief prompts and an open-ended question. Medication management should use checkboxes for organization methods. EMR integration and regular updating of dynamic information were noted as priorities.

Conclusions: Interviews revealed clear opportunities to align the intake process with the 4Ms. Adding concise What Matters prompts, expanding functional and safety items, and simplifying medication documentation may improve identification of patient priorities and risks. EMR integration could strengthen accuracy and workflow. Findings will guide development of a revised form and a pilot implementation. Future phases will assess effects on efficiency, team communication, patient satisfaction, and consistency of 4Ms-based care.

C188 Student Presentation

Huddle Up: How Provider Huddles Moved the Ball Forward on ACP Documentation

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Background:

Advanced care planning (ACP) is critical for communicating patient preferences. Despite the acknowledged importance, completion rates in primary care settings remain low. We developed a quality improvement (QI) intervention, as part of a larger initiative to increase ACP within an ambulatory geriatric primary care practice (geri-PCC).

Methods:

Our QI intervention consisted of identifying patients without documented Advanced Directives (AD) or Practitioner Orders for Life-Sustaining Treatment (POLST) forms in the electronic medical record (EMR) and adding a "missing ACP" notification to each provider's daily huddle sheet. We compared the rate of AD or POLST captured in the EMR, and ICD-10 codes billed for ACP/Goals of Care (GOC) in the geri-PCC during the six months prior to the intervention and during the intervention period (two consecutive six-month periods). Pairwise comparisons of the proportion of signed documents and billing codes were analyzed using Pearson chi-square tests.

Results:

Patient demographics and presence of comorbidities were similar across the three study periods. Median age range for our cohort was 79-81, with 70% female and 65% white. Living Will (LW) documentation increased during intervention period 1 (8.2% to 10.3%, $p = 0.027$) and decreased during intervention period 2 (10.3% to 5.4%, $p < 0.001$). Durable Power of Attorney (dPOA) documentation followed a similar trend of increase during intervention period 1 (2.9% to 6.2%, $p < 0.001$) and decrease during intervention period 2 (6.2% to 3.9%, $p = 0.003$). For POLST, there was no evidence of change during intervention period 1; however, the rate decreased in intervention period 2 (6.1% to 3.9%, $p = 0.003$). ICD-10 codes

billed for ACP/GOC increased slightly during intervention period 1 (12.9% to 15.0%, $p = 0.057$) and decreased during intervention period 2 (15.0% to 8.9%, $p < 0.001$).

Conclusions:

Incorporating a “missing ACP” notification to provider huddles was associated with increased AD documentation in the first six months. There was also a trend toward increased billing of ACP/GOC codes during this period. However, this did not persist in the second six-month period. Further exploration is needed to develop long-term sustainability.

C189 Student Presentation

Impact of a Structured Deprescribing Intervention on Anticholinergic Burden in Hospitalized Older Adults

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Background:

Older adults are frequently exposed to medications with substantial anticholinergic burden (ACB), as measured by the Anticholinergic Cognitive Burden Score. Higher ACB scores are linked to confusion, blurry vision, somnolence, and other adverse outcomes. The quality improvement project sought to determine whether a deprescribing intervention reduces anticholinergic toxicity.

Methods:

The ongoing project implemented a structured deprescribing intervention to reduce polypharmacy and assess its impact on ACB. Real-time patient identification and messages through a secure system alerted providers on the inpatient medicine service for patients aged 80+, prescribed at least one Potentially Inappropriate Medication (PIM), and taking ≥ 5 medications. We tracked changes in total medications and ACB score pre- and post-intervention.

Results:

Patients (N=63) were identified from July to November 2025. The median percentage decrease in total medications from pre- to post-intervention was 17.26% (SD 36; range -100 to 60). Several high-anticholinergic burden agents were deprescribed, including diphenhydramine, tramadol, prochlorperazine, opioids, and antimuscarinic drugs. Most increases were from adding vitamins or laxatives.

ACB scores decreased in 33% of patients, including three patients who reached a score of 0. Pre- vs. post-intervention SDs were 2.19 and 1.92, with changes in scores ranging from -6 to +6 (SD 2.27). Less frequent increases typically involved restarting home medications like PPIs or antidepressants.

Conclusions:

This structured deprescribing intervention led to a 17% median reduction in total medications and 33% of patients lowering their ACB score. These findings support real-time communication and targeted deprescribing as effective strategies to address anticholinergic toxicity in older adults.

C190 Student Presentation, Encore Presentation

Outcomes in patients ≥ 70 years receiving fludarabine/melphalan 100 mg/m² (FluMel100) conditioning with post-transplant cyclophosphamide (PTCy) in allogeneic hematopoietic cell transplantation (Allo-HCT)

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Background:

AML and MDS primarily affect older adults, with median ages near 70 years. Allo-HCT is the only curative therapy but is underutilized in older patients due to concerns about frailty, toxicity, and

transplant-related mortality. Reduced-intensity conditioning with FluMel and PTCy has expanded transplant access, but the safety and engraftment profile of FluMel100 allo-HCT in patients ≥ 70 years remain unclear.

Methods:

We conducted a retrospective study of adults receiving FluMel100 with PTCy from March 2022-March 2025, stratified by age <70 vs ≥ 70 years. Outcomes included 1-year overall survival (OS), relapse-free survival (RFS), 100-day survival, relapse, transplant-related mortality, acute GVHD (MAGIC), engraftment, and hospital stay. Mann-Whitney U and Fisher's exact tests were used for comparisons; survival and engraftment were analyzed with Kaplan-Meier and log-rank tests.

Results:

59 patients were included (<70 n=34; ≥ 70 n=25). Median follow-up was 416 vs 179 days; median ages were 65 vs 73 years ($p < 0.001$). Most patients had AML/MDS and received unrelated donor grafts with PTCy/tacrolimus/mycophenolate prophylaxis; a minority received sibling donors. 1-year OS was 88.2% vs 92.0% ($p=0.08$). 1-year RFS was 76% in both groups ($p=0.20$). 100-day survival was 96.0% vs 91.2% ($p=0.48$). Rates and severity of aGVHD were similar (63% vs 56%, $p=0.30$), with comparable onset (42 vs 39 days). Median hospital stay was identical (22 days). Engraftment occurred in 32/34 and 24/25 patients. Median ANC recovery $>500/\mu\text{L}$ occurred at 14.5 vs 15 days ($p=0.24$). Platelet recovery $>20 \times 10^9/\text{L}$ was faster in patients <70 (22 vs 27.5 days, $p=0.03$), as was $>50 \times 10^9/\text{L}$ (27 vs 29 days, $p=0.03$).

Conclusion:

FluMel100 allo-HCT with PTCy yielded similar survival, GVHD, and neutrophil recovery in adults ≥ 70 compared with younger patients. Platelet recovery was modestly delayed in older adults, but this did not affect relapse or mortality. FluMel100 with PTCy is feasible in well-selected patients ≥ 70 years. Further study will assess drivers of delayed platelet recovery and long-term outcomes including GRFS and cGVHD.

C191 Student Presentation, Encore Presentation

Comparative outcomes of 80 mg/kg vs 100 mg/kg post-transplant cyclophosphamide following fludarabine-melphalan 100 conditioning in allogeneic hematopoietic cell transplantation

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Background:

Post-transplant cyclophosphamide (PTCy) is widely used for GVHD prophylaxis after reduced-intensity allo-HCT. The standard 100 mg/kg regimen reduces toxicity compared with calcineurin inhibitor platforms. Emerging haploidentical data suggest that a lower dose (80 mg/kg) may offer similar GVHD protection with less toxicity, but comparative data in FluMel100 allo-HCT remain limited.

Methods:

We performed a single-center retrospective analysis of adults receiving FluMel100 allo-HCT with 80 mg/kg (PTCy80) or 100 mg/kg (PTCy100). Outcomes included 1-year overall survival (OS), relapse-free survival (RFS), relapse, transplant-related mortality, engraftment, hospital stay, acute GVHD (MAGIC), GVHD timing/organ distribution, and immunosuppression duration.

Results:

Fifty-four patients (27/group) were analyzed. Median follow-up was 213 days (PTCy80) and 630 days (PTCy100). The PTCy100 cohort was older (72 vs 66 years, $p < 0.001$). AML was the most common indication; 26/27 in each group received matched unrelated donor peripheral blood grafts. Median hospitalization was similar (22 vs 23 days).

At 1 year, OS was 92.6% (PTCy80) vs 88.9% (PTCy100, $p = 0.85$), and RFS did not differ (log-rank $\chi^2 = 0.086$, $p = 0.77$). Relapse incidence (18.5% both) and transplant-related mortality were similar.

Acute GVHD occurred more often and earlier with PTCy80 (63% vs 33%, $p = 0.02$), driven by higher grade 1-2 disease (48% vs 19%). Severe GVHD (grade 3-4) remained comparable (7% vs 15%). Median onset was earlier with PTCy80 (39 vs 44 days, $p = 0.03$).

Engraftment occurred in 26/27 patients in each group. Median ANC recovery $>500/\mu\text{L}$ occurred at 14.5 vs 16 days ($p = 0.17$), and platelet recovery $>20 \times 10^3/\mu\text{L}$ at 25.5 vs 27 days ($p = 0.86$).

Conclusion:

In FluMel100-conditioned allo-HCT, reducing PTCy from 100 to 80 mg/kg resulted in similar engraftment, relapse, and survival. Although low-grade, earlier-onset aGVHD was more frequent with PTCy80, severe GVHD and mortality were comparable. These findings suggest PTCy80 maintains efficacy while reducing cumulative exposure. Ongoing analyses will assess chronic GVHD, GRFS, and toxicity.

C192 Student Presentation

Improving Nurse Confidence in Delirium Identification with Confusion Assessment Method Training

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Delirium is a key component of inpatient and nursing home Age-Friendly care. Classified as a geriatric emergency, the condition has been linked with extended length of stay, decreased likelihood of returning home, functional decline, and mortality. One main assessment tool is the confusion assessment method (CAM), which assesses 4 features: acute onset and fluctuating course, inattention, disorganized thinking, and an altered level of consciousness. Proper understanding and application of the CAM is vital for early and accurate identification of at-risk patients to lessen the consequences of delirium. Frontline nurses often hold responsibility for the initial assessment; however, underdiagnosis of delirium is extremely common. The objective of this study was to measure the impact of in-service education for nurses working in a long-term care setting. The main outcome measure was nurses' confidence in the identification of delirium.

The study was set in the Greater Los Angeles VA Community Living Center and consisted of a delirium education intervention for nurses followed by a self-assessment retrospective pre/post survey. The nurses received a one-time presentation focused on the importance and implementation of Age-Friendly care, and how to differentiate delirium from dementia and then they self-evaluated their confidence in identifying delirium after the training compared to pre-training.

Post-training confidence was analyzed using paired-sample t-tests. There was a significant improvement in confidence with identifying inattention ($p=0.01$) and understanding which features of the CAM are diagnostic for delirium ($p=0.04$). The average overall post-training confidence was 3.6/4 ($n=22$).

Delirium education was shown to improve nursing confidence in identifying features of delirium. Post-test queries on confidence – like the surveys used in the study – have been shown to predict clinical behaviors. The rise in confidence may translate to improvements in delirium identification accuracy which could facilitate clear care team communication and earlier intervention to decrease delirium risk and enhance Age-Friendly care. Accurate delirium identification would also allow for further study of delirium prevention and improvement on outcomes such as falls, length of stay and healthcare system costs.

C193 Student Presentation

Early Physician Feedback on the Implementation of Interdisciplinary Dementia Case Conferences

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Dementia is an increasingly prevalent condition among older adults and is managed by multiple medical specialties including geriatrics, neurology, and geriatric psychiatry. In addition, the advent of anti-amyloid monoclonal antibody therapy has added another complex factor to dementia care. To enhance care coordination, our institution implemented interdisciplinary dementia case conferences involving all three specialties. These conferences have also served as an opportunity for neurology to provide other specialties with updates on the use of anti-amyloid therapies at our institution and to streamline the referral and workup process for anti-amyloid therapies. This project utilized qualitative data from surveys distributed to the physicians participating in the dementia case conferences. The primary measures were physician satisfaction, perceived impact on clinical practice, and reported changes in confidence in clinical decision-making.

Preliminary feedback obtained approximately four months after initiating the case conferences indicates satisfaction with the dementia case conferences. Providers specifically noted satisfaction with the open-forum style and with being provided updates on best practices regarding anti-amyloid therapy. Impacts geriatricians noted on their clinical practice included feeling more comfortable ordering and providing counseling on biomarkers. Neurology noted the conferences have served as an opportunity to provide information on which patients would most benefit from a referral for anti-amyloid therapy. Geriatricians in particular reported improved confidence in clinical decision-making since participating in the case conferences along with improved confidence in managing similar patients independently in the future.

This preliminary feedback supports continued utilization of interdisciplinary case conferences in dementia management at our institution. Scheduled opportunities for discussion across specialties have appeared to improve physician confidence and streamline decision-making, and regular updates on best practices regarding biomarkers and anti-amyloid therapies have facilitated efficient and consistent communication across specialties. As diagnostic tools and therapies in dementia care continue to evolve, interdisciplinary meetings will aid in ensuring appropriate and efficient use of diagnostics and specialty referrals moving forward.

C194 Student Presentation

Use of In-Person Visits in a Primarily Telemedicine Cognitive Geriatric Program

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Background:

The Telemedicine Cognitive Geriatric Program (TCGP), a grant funded and pilot program of the NYC Health and Hospitals Bellevue, serves a diverse patient population throughout the city of New York. Launched in 2024, the TCGP provides cognitive evaluations and management of mild cognitive impairment and dementia using telehealth services. However, some patients require in-person visits. We aimed to understand the characteristics of patients requiring in-person appointments.

Methods:

We conducted a retrospective chart review of patients seen between November 12th, 2024, and November 21st, 2025, at the TCGP. We identified the number of in-person versus telehealth visits. For in-person encounters, we collected patient age, the neighborhood in which the patient lives, the diagnosis at the time of the visit, whether the diagnosis changed during the visit, and if the patient had a care partner or not.

Results:

Between November 12th, 2024 and November 21st, 2025, a total of 249 visits were completed by the TCGP, 48 of which (19%) were conducted in person. Of the patients who required in-person visits, the average age was 77. Their diagnosis breakdown was no cognitive impairment (n=13; 27%), mild cognitive impairment (n=12; 25%), mild dementia (n=13; 27%), mild to moderate dementia (n=5; 11%), moderate dementia (n=3; 6%), and severe dementia (n=2; 4%). Eight visits consisted of diagnostic changes (17%). Ten patients with in-person visits did not have a care partner (21%). Most patients who had in-person visits lived in Manhattan (n=26; 54%) or Brooklyn (n=13; 27%). Few were in Queens (n=5; 11%), the Bronx (n=2; 4%), and Staten Island (n=2; 4%). When a reason was cited for the in-person visit, it was typically due to issues accessing video on the telehealth call (n=6).

Conclusions:

Less than 20% of patients receiving telehealth consultation for cognitive impairment detection and management required an in-person visit, and half of those are at the mild stage, and a quarter without objective cognitive impairment. Those with more advanced stages could be assessed and managed using telemedicine. Our study supports a hybrid dementia care approach integrating telehealth and in-person services for optimal delivery.

C195 Student Presentation

Evaluating the Implementation of HELP (Hospital Elder Life Program) Interventions in the UT Southwestern Emergency Department

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Delirium is a transient state of confusion involving decreased awareness of surroundings and cognitive capabilities. Given its associated morbidity and mortality, delirium is a major concern among geriatric patients. AGS CoCare Hospital Elder Life Program (HELP) is an evidence-based program where volunteers implement interventions to prevent delirium and functional decline of older hospitalized patients. UT Southwestern is a recognized HELP site, with UTD undergraduate students volunteering in inpatient units at Clements University Hospital. In 2023, the program was expanded to the Emergency Department (ED). Some interventions that volunteers implement to prevent delirium in inpatient units, such as opening curtains to let in natural light and ordering food to ensure adequate nutrition, are unable to be practiced in the ED due to a lack of windows and nutrition services for ED patients. Therefore, volunteers emphasize companionship and hydration while visiting ED patients. HELP's impact in inpatient settings has been extensively studied, however the expansion of HELP to the ED has not been described. To evaluate HELP's implementation in the ED, we conducted separate questionnaires for both ED staff and patients seen in the ED by HELP volunteers. 4 patients completed a questionnaire about their HELP volunteer visit, with 75% reporting that the HELP volunteer improved their comfort levels while in the ED. 10 nurses completed the healthcare workers' questionnaire, of which 75% reported companionship as one of the most beneficial aspects for ED patients. 50% reported that delirium education was one of the most beneficial aspects for offloading work from the healthcare team. However, 72.7% reported not being familiar with HELP in general. In open-ended responses for program suggestions, 2 nurses suggested HELP volunteers increase communication with staff when visiting patients. Study limitations included low response rates and the busy ED environment preventing questionnaire completion. Based on these results, expanding HELP practices into emergency departments of hospitals may be beneficial to providing delirium education and companionship to prevent delirium during patients' ED stays. To better integrate HELP into the ED, efforts may include increasing ED-specific volunteers and providing HELP educational materials for patients and staff.

C196 Student Presentation

Impact of Infection Control Precautions Post-COVID on Hospitalized Geriatric Patients

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Background: Social isolation during the COVID-19 pandemic had significant negative impacts on older adults, including cognitive and functional decline. Prior data suggest patients in isolation rooms receive fewer and shorter staff visits, (1) but it is unclear how post-COVID attitudes impact these staff entries. This QI project explores post-COVID hospital staff visitation patterns to isolated geriatric patients, measured by visit length and frequency on a mixed palliative care and medicine unit.

Methods: A volunteer was placed daily between 7:30-11:00 AM with a clear view of four rooms. Entry/exit times and visiting staff role (nurses, personal care associates (PCA), or other staff) were recorded on a standardized form and compiled with patient age, gender, and isolation precaution type. Patients were observed for two consecutive days; patients with incomplete data were excluded from analyses. Two-tailed T-tests were used to compare isolated and nonisolated groups.

Results: Preliminary outcomes suggest visit length between isolated and nonisolated older adults (≥ 65 y) differed significantly ($p=0.006$): providers spent 137.0% longer with isolated (n=6) than nonisolated patients (n=39) (mean=6.2 vs 2.6 min). This trend held across all provider groups. A nonsignificant difference in visit frequency was seen: overall, staff visited isolated patients 39.1% less often than nonisolated patients (mean=2.4 vs 3.9 visits/hr, $p=0.06$). Nurses accounted for a significant difference in frequency (isolation mean=1.3 vs nonisolation mean=2.2 visits/hr, $p=0.007$). Nonsignificant differences in visit frequency (PCA mean=0.46 vs 0.92, $p=0.20$; Other mean=0.47 vs 0.90, $p=0.26$) were seen in other staff. Equivalent data was collected for non-geriatric patients (n=21, <65 y), with no significant age differences observed.

Discussion: While geriatric patients in isolation on this unit received longer but less frequent visits from nursing staff, overall care still exceeded the hospital's standard for nursing rounds. However, it remains unclear whether the mental and physical health of geriatric patients benefits more from longer visits or more frequent ones—an important question for future research.

1) Dashiell-Earp CN, Bell DS, Ang AO, Usulan DZ. Do Physicians Spend Less Time with Patients in Contact Isolation? A Time-Motion Study of Internal Medicine Interns. JAMA Intern Med. 2014;174(5):814–815. doi:10.1001/jamainternmed.2014.537

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