SESSION 3420 (PAPER)

ISSUES IN ACUTE CARE

ACUTE CARE UTILIZATION IN OLDER ADULTS LIVING UNDIAGNOSED OR UNAWARE OF DEMENTIA

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Most individuals with dementia are undiagnosed or they/their families are unaware of the diagnosis. Implications of dementia diagnosis and awareness are poorly understood. Our objective was to determine whether undiagnosed dementia or unawareness increases risk of hospitalization or emergency department (ED) visits, outcomes with recognized risk in diagnosed dementia. We linked National Health and Aging Trends Study (NHATS) data to fee-for-service Medicare claims for 4,311 community-living participants in the nationally representative cohort. We assessed probable versus no dementia using validated NHATS dementia criteria, undiagnosed versus diagnosed using Medicare claims, and aware versus unaware using NHATS self or proxy report of diagnosis. Cox proportional hazards models evaluated hospitalization and ED visit risk by time-varying dementia diagnosis and awareness status, adjusting for sociodemographic characteristics, functional impairment, medical comorbidities, and prior hospitalization. Compared to no dementia, persons with dementia who were unaware but diagnosed had greater risk of hospitalization (HR 1.66, 95% CI 1.26-2.19) and ED visits (HR 1.63, 95% CI 1.28-2.08). Persons unaware but diagnosed also had greater risk compared to persons aware and diagnosed (hospitalization HR 1.34, 95% CI 0.98-1.82; ED HR 1.38, 95% CI 1.05-1.83). Persons with undiagnosed dementia demonstrated hospitalization risk similar to persons with no dementia (HR 1.02, 95% CI 0.79-1.31) and similar or potentially lower than persons aware and diagnosed (HR 0.82, 95% CI 0.61-1.10); ED visit findings were similar. Results suggest that being unaware of dementia diagnosis may affect healthcare utilization. Strategies to improve communication and understanding of dementia could potentially reduce hospitalizations and ED visits.

FAMILY CAREGIVER FACTORS AND HOSPITALIZATION IN DISABLED OLDER ADULTS WITH AND WITHOUT DEMENTIA

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Older adults with disabilities commonly rely on family caregivers’ help, yet effects of caregiver factors on patient outcomes are poorly understood. Within this population, dementia is common. Our objective was to evaluate the association between caregiver factors and risk of hospitalization in disabled older adults with and without dementia. We examined 2,589 community-living older adults with mobility/self-care disability and their primary family caregiver in four waves of the National Long-Term Care Survey and National Health and Aging Trends Study. We used Cox proportional hazards models to examine risk of one-year, Medicare claims-derived, all-cause hospitalization as a function of caregiver factors, adjusting for older adult characteristics (sociodemographics, comorbidities, healthcare utilization) and survey year, considering dementia a characteristic of interest. Among disabled older adults, 38% were hospitalized over one year, and 31% had probable dementia. Hospitalization rates were similar for older adults with and without dementia (39.5% and 37.3% respectively); dementia was not associated with hospitalization risk (HR 1.09, 95% CI 0.95-1.26). Older adults demonstrated greater risk of hospitalization if their caregiver was male (HR 1.31, 95% CI 1.10-1.56), new to caregiving (HR 1.61, 95% CI 1.27-2.04 for <1 year versus ≥4 years), or helped with healthcare tasks (HR 1.21, 95% CI 1.04-1.41). The association between most caregiving factors and hospitalization risk did not differ by dementia status. Results suggest that strategies to reduce hospitalization in older adults with disabilities could target select caregivers using similar strategies in populations with and without dementia.

HOSPITAL CARE USE IN OLDER ADULTS: THE ROLE OF PSYCHOLOGICAL AND SOCIAL FACTORS

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Although older people’s health status is the main determinant of healthcare use, there has been little research on how psychosocial factors relate to healthcare utilization. We explored the extent to which psychological and social aspects predict the use of hospital care in an older Swedish population. 2867 people ≥60 years from the Swedish National study on Aging and Care in Kungsholmen (SNAC-K) were followed from baseline (2001-2004) for four years. We created standardized indexes of psychological well-being, and social well-being. Binominal negative mixed models were used to estimate the association of psychological and social indexes with hospital care use (i.e. unplanned hospital admissions [UHA], 30-day readmissions [30DR] and length of stay [LOS]). Individuals with a psychological well-being score above the median had less UHA (IRR 0.43, 95% CI 0.20-0.93) and lower LOS (IRR 0.18, 95% 0.06-0.58), even after full adjustment. High levels of social well-being were also protective for UHA and LOS in the minimally adjusted model, but not after adjusting by life style and personally traits. Relative
to individuals with poor well-being on both indexes, those with rich psychological and poor social well-being had reduced hospital care use (IRR 0.44 95%CI 0.24-0.84; IRR 0.23, 95%CI 0.08-0.67, respectively), and even further in those with rich psychological and social well-being (IRR 0.33 95%CI 0.14-0.75; IRR 0.10, 95% 0.02-0.45, respectively). No statistically significant association was found with 30DR. Provided the importance of psychosocial aspects in predicting UHA and LOS, targeting the former could be a strategy for reducing healthcare use and, eventually, costs.

IMPLEMENTING A GERIATRIC FRACTURE PROGRAM IN A PLURALISTIC ENVIRONMENT REDUCES LENGTH OF STAY AND TIME TO SURGERY
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Geriatric-orthopaedic co-management models have been demonstrated to improve patient outcomes, but are typically implemented in closed, non-pluralistic medical systems. The Cedars-Sinai Geriatric Fracture Program (GFP) was developed through collaboration amongst a multi-disciplinary group. Cedars-Sinai is an academic medical center with a pluralistic medical staff that includes faculty, several hospitalist groups, and private practitioners. The GFP was introduced in July 2018 as a quality improvement pilot to provide standardized treatment for geriatric fracture patients. We hypothesized GFP enrollment would reduce time to surgery (TTS) and length of stay (LOS). Geriatric fracture patients were prospectively enrolled from July-December 2018. The Wilcoxon Rank-Sum test was used to compare TTS and LOS between the two patient groups. A p < 0.05 was considered significant. 190 operative fractures in patients over 65 years-old were prospectively followed. 56 (30%) were enrolled in the GFP, 54 (28%) were admitted to other hospitalist groups (OH), and 80 (42%) were managed by their primary care physician (PCP). There were no demographic differences between patient groups. Patients enrolled in the GFP had a significantly shorter LOS compared to the OH and PCP groups (4 days vs 5 days vs 5 days, p = 0.039) as well as a significantly shorter TTS (19.7 hrs vs 22.4 hrs vs 23.3 hrs, p = 0.037). Our data shows that a multi-disciplinary geriatric fracture program can be successfully implemented in a complex pluralistic environment resulting in improved patient metrics. Adherence to evidence-based protocols and close multidisciplinary teamwork are critical to program success.

IN-HOSPITAL NURSE CARE CONTINUITY: DOES IT MATTER?
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In-hospital cognitive decline affects up to 40% of hospitalized older adults and is associated with post-hospitalization worsening of medical and functional status. Studies pointed to the substantial role of the interpersonal relationship between older adults with cognitive impairment and the nurses who care for them. We investigated the association between nursing interpersonal continuity and cognitive outcomes in a cohort of 646 older adults aged 70 or older admitted to internal units for non-disabling conditions. Cognitive decline was defined as at least one point decline in the Short Portable Mental Status Questionnaire from admission to discharge assessments. Nursing interpersonal continuity was measured using continuity of care index (CoC). CoC assesses the extent of different nurses assigned to take care of each patient during the hospital stay (2 shifts per day) and ranges from 0 (none of the nurses is the same) to 0.4 (highest feasible score according to full time standard shift plan and length of stay (LOS)). Multivariate logistic regression showed that achieving 25% of the highest feasible in-hospital nursing CoC was associated with lower odds of cognitive decline (OR=0.67, 95% CI=0.47-0.97), controlling for age, sex, premorbid activities of daily living status, at admission cognitive status, comorbidities, severity of illness and LOS. This study shows that in-hospital nursing continuity is negatively associated with older adults’ cognitive decline, even in low-continuity levels. Future studies should investigate in-hospital continuity patterns and interventions maintaining continuity in larger and more heterogenic samples.

SESSION 3425 (SYMPOSIUM)

IT’S THE LITTLE THINGS THAT COUNT: IMPLICATIONS OF DAILY EXPERIENCES FOR WELL-BEING AND BIOLOGICAL INDICATORS
Chair: Kira S. Birditt, Institute for Social Research, University of Michigan, Ann Arbor, Michigan, United States

Middle-age and older adults vary widely in their physical health. This symposium describes studies that identify diverse daily experiences that account variation in health using multiple indicators of well-being (self-reported, biological). Fingerman et al. assessed daily TV viewing among older adults and found that more frequent television watching was associated with poorer physical health, worse health behaviors, and less energy expenditure (via actical watch). Leger et al., examined links between daily affect and sleep. Greater variability in daily positive affect is associated with fewer hours of sleep and greater morning tiredness even after adjusting for mean levels of affect. Luong et al. examined links between daily stress and affect. Interpersonal stressors were associated with greater affect reactivity than non-interpersonal stressors and links were reduced among older adults. Birditt et al. assessed links between daily social interactions and cardiovascular reactivity. More frequent social interactions and negative social interactions were associated with increased heart rate and links varied by gender and race. Polenick et al. examined links between daily social interactions and salivary DHEA-S (a marker of the stress response). Positive interactions predicted greater DHEA-S over the course of the day and links between negative interactions and DHEA-S varied by age group such that younger individuals appeared to be more reactive. These studies offer important clues regarding how daily experiences get under the skin to influence health and well-being.