Abstracts from the 44th Annual Scientific Meeting of the Canadian Geriatrics Society

Enhancing Care for Vulnerable Populations: Addressing Challenges and Equity in Canada's Healthcare System; May 29–31 2025; Toronto, Ontario

https://doi.org/10.5770/cgj.28.884

FINALISTS FOR THE WILLARD AND PHOEBE THOMPSON AWARD

Does the Change in Frailty After Hip Fracture Surgery Relate to Health Outcomes?

Alanna Bohnsack[1], Karla Faig[2], Andrew J Flewelling[2], Aidan Steeves[2], Olga Theou[3], Pamela Jarrett[4].
[1]Dalhousie Medicine New Brunswick; [2]Horizon Health Network; [3]Dalhousie University; [4]Dalhousie Medicine New Brunswick; Horizon Health Network.

Background/Purpose: Frailty in older adults can increase the risk of adverse health outcomes after surgery. This retrospective study investigated how the change in frailty scores following hip fracture relates to health outcomes.

Method: The Pictorial Fit-Frail Scale (PFFS) scores were determined retrospectively by review of hospital electronic health records (EHRs) pre-admission and five days post-surgery on a random sample of 181 hip fracture patients 65 years and older. The change in PFFS scores were categorized as: no change (0 to <4), mild (4 to <8), moderate (8 to <12), and severe change (12 or greater). Associations between frailty change categories and length of stay (LOS), mortality, discharge location, and alternate level of care (ALC) days in acute care were analyzed using partial correlations.

Results: The average age was 83.1 years (SD 8.2) and 74.0% female. The mean PFFS scores were 10.9 (SD 7.4) prior to admission and 19.2 (SD 5.5) five days post-surgery. Almost a quarter (23.2%) had a severe change in PFFS score and 39.2% had a mild or no change. There was a statistically significant positive correlation between the magnitude of change of the PFFS score and the LOS (r=0.21), ALC days (r=0.23), mortality (r=0.22), and not returning home (r=0.46) when controlling for age and PFFS pre-admission.

Discussion: Health data collected in hospital EHRs can be used to determine frailty levels pre-admission and post-surgery. The change in frailty, measured by the PFFS, correlates with health outcomes. Patients with severe changes in frailty post-surgery have worse health outcomes.

Association Between Non-English Language and Use of Restraints in Hospitalized Older Adults with Dementia

Alexa Gruber[1], Craig Bryan[1], Ahmed Aldarraji[2], Andrew Stein[3], Saeha Shin[4], Kathleen Sheehan[5], Shail Rawal[1], Christina Reppas-Rindlisbacher[1].
[1]Medicine, University of Toronto; [2]Medicine, McMaster University; [3]Medicine, University of Ottawa; [4]Medicine, Western University; [5]Psychiatry, University Health Network.

Background/Purpose: Non-English-speaking inpatients in English-predominant hospitals are at increased risk of hospital harms and physical restraint use compared to English speakers. We examined whether non-English language preference was associated with increased use of physical or chemical restraints in hospitalized older adults with dementia.

Method: We conducted a retrospective cohort study of medical inpatients aged 65+ with dementia admitted to a hospital network in Toronto, Canada between June 1, 2022 and July 1, 2023. We screened 1,233 charts using a validated abstraction tool for dementia and included 596 charts for review of patient characteristics and physical or chemical restraint use. We used multivariable regression, utilizing log-link binomial generalized linear models to estimate relative risks for outcomes, adjusting for variables which influence restraint use.

Results: In 596 patients, the median age was 86 years (IQR 11), 208 (34.9%) were prescribed new antipsychotics, 77 (12.9%) were prescribed new sedative-hypnotics, and 134 (22.5%) received physical restraints. Compared to English speakers, patients with a non-English language preference had increased risk of receiving physical restraints (18.2% vs 27.2%; aRR 1.37, 95% CI 1.02-1.86), but not of receiving

© 2025 Author(s). Published by the Canadian Geriatrics Society. This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial No-Derivative license (https://creativecommons.org/licenses/by-nc-nd/4.0/), which permits unrestricted non-commercial use and distribution, provided the original work is properly cited.

antipsychotics (aRR 1.03, 95% CI 0.85-1.25) or sedative-hypnotics (aRR 1.45, 95% CI 0.95-2.21).

Discussion: Medical inpatients with dementia who spoke non-English languages were 1.37 times more likely to be physically restrained compared to English speaking patients. Addressing language barriers may help reduce restraint use in this already marginalized group. Our findings demonstrate evidence of disparities in physical restraint use by language preference for inpatients with dementia.

Prioritizing Older Adults in Climate Change Adaptation Policies: A Policy Document Analysis Across Canada

Anumita Jain[1], Gabrielle Katz[1], Kristina M Kokorelias[2], Nathan M Stall[3].
[1]MD Program, University of Toronto; [2]Division of Geriatrics, Sinai Health; [3]Division of Geriatrics, Sinai Health, Department of Medicine, University of Toronto.

Background/Purpose: Older adults face disproportionate morbidity and mortality from climate change due to heightened risk of heat-related illness, reduced mobility during climate emergencies, increased reliance on caregivers, and cardiorespiratory distress from air pollution. Prior analyses described the inclusion of older adults in US climate plans, but Canadian plans remain unstudied. Identifying these gaps is critical to ensuring Canadian policies protect the health and well-being of older adults. We examined the inclusion of older adults in Canadian climate plans and climate-related considerations in seniors' strategies.

Method: We identified current Canadian climate plans and seniors' strategies from federal, provincial, and territorial governments through government websites. Informed by prior research, we searched for 11 climate-related keywords in seniors' strategies and 8 older adult-related keywords in climate plans. We coded mentions dichotomously (yes/no) and analyzed using qualitative thematic analysis.

Results: Of 23 documents analyzed, only 4 (Canada's climate plan, Prince Edward Island's (PEI) and British Columbia's (BC) climate plans, and Quebec's seniors' strategy) included at least one keyword. PEI and BC recommended heat alert systems and emergency preparedness. Canada recommended minimizing carbon pollution. Quebec focused on educating older adults about climate risks.

Discussion: The health impacts of climate change on older adults were minimally included, likely due to limited awareness and competing priorities. The US and UK offer valuable recommendations, such as improving community infrastructure resilience, that could strengthen Canadian plans. In conclusion, Canadian plans lack actionable steps to mitigate climate risks for older adults. Future research is needed to understand the clinical implications of these inclusions.

Use of Dual Orexin Receptor Antagonists for Insomnia and the Risk of Falls and Fractures: A Systematic Review and Meta-analysis

Arianna Paolone[1], Shehraz Riar[2], Shajjan Vejayavarnan[3], Justin Lee[4].
[1]Department of Medicine, Royal College of Surgeons in Ireland, Dublin, Ireland; [2]Faculty of Health Sciences, McMaster University, Hamilton, Canada; [3]Department of Medicine, University of Limerick, Limerick, Ireland; [4]Division of Geriatric Medicine, Department of Medicine, McMaster University; Centre for Integrated Care, St. Joseph's Health System, GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada.

Background/Purpose: 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. We conducted a systematic review to assess the effect of DORAs on falls and fractures.

Method: We searched MEDLINE, EMBASE, and CENTRAL for studies reporting falls and fractures in DORA users and non-users. Citation screening, full-text review, data abstraction and risk of bias assessment were conducted in duplicate. Random-effects model meta-analyses were conducted.

Results: Twelve studies (7 RCTs, 5 observational, 143,885 participants) met inclusion criteria. Based on the totality of evidence, DORA use did not increase the risk of falls compared to non-use (OR 0.86, 95% CI 0.62–1.18). RCT data suggests a possible reduction in fall risk (OR 0.62, 95% CI 0.35–1.08) not seen in observational studies (OR 1.07, 95% CI 0.72–1.59). No association was observed between DORAs and fractures (OR 1.05, 95% CI 0.94–1.18).

Discussion: DORAs may reduce fall risk and be a safer alternative to other medications for insomnia, 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. DORAs do not appear to increase the risk of falls or fracture, but additional research is needed to confirm their safety in older adults.

Factors Associated with Older Adults' Adherence to Health and Social Care Recommendations: A Cross-Sectional Study

Mkeila Sowa[1], Karen D'Silva[1], Evelyn Cheung[1], Sharon Marr[1], Jennifer Watt[1].
[1]Unity Health Toronto.

Background/Purpose: Older adults face challenges adhering to care recommendations. To inform tailoring of a program to improve recommendation adherence, we examined factors associated with recommendation adherence.

Method: We reviewed medical records of patients aged ≥65 years who underwent a comprehensive geriatric assessment at St. Michael's Hospital (SMH) between July 1, 2022, and June 30, 2024. We abstracted patients' age, sex, living arrangement, frailty (Clinical Frailty Scale score), education, cognitive impairment history, preferred language, immigration history, family or friend caregiver involvement, polypharmacy, and pharmacologic and nonpharmacologic recommendation adherence. We derived odds and predicted probabilities of nonadherence to pharmacologic or nonpharmacologic recommendations from logistic regression models, adjusting for abstracted characteristics.

Results: We included 240 patients whose mean age was 81.2 (standard deviation 7.4); 53.3% were women. Living alone (odds ratio [OR] 7.8, 95% confidence interval [CI] 2.2-38.3) was associated with greater odds of pharmacologic recommendation nonadherence; living alone (OR 4.0, 95% CI 2.0-8.3) and cognitive impairment (OR 2.5, 95% CI 1.1-6.2) were associated with greater odds of nonpharmacologic recommendation nonadherence. Our model predicted that a mildly frail 80-year-old woman living with a caregiver would adhere to 93.6% of pharmacologic and 88.1% of nonpharmacologic recommendations compared to 65.1% of pharmacologic and 64.7% of nonpharmacologic recommendations if she lived alone.

Discussion: We highlight the importance of targeting interventions to improve adherence at older adults who live alone.

Improving Practices of Information Transfer between Hospitals and Primary Care for Older Adults

Carolyn Pavoni[1], Sandrine Couture[1], Aigul Zaripova[1], Claire Godard-Sebillotte[1], Dimitri Yang[2], Martina Alkot[2].
[1]McGill University; [2]McGill University, Faculty of Medicine.

Background/Purpose: Geriatricians play a crucial role in caring for older adults, often making new diagnoses or medication changes during a hospital stay. However, there is no systematic process for transferring geriatrician notes to primary care physicians (PCPs), causing a loss of information. This study aims to describe the transfer of geriatrician plans to outpatient providers, identify barriers and facilitators to implementing best practices, and generate evidence-based recommendations to improve this transmission.

Method: First, we developed a survey sent to geriatricians about information transfer practice and performed a descriptive analysis. Second, we conducted 20-minute semi-structured interviews with geriatricians and performed a thematic content analysis. Third, we are conducting a scoping review of the literature to identify existing practices and suggest practices of information transfer.

Results: Key survey results indicated that although geriatricians believe that consult notes should be sent to PCPs and that lacking a systematic procedure negatively impacts the quality of care, only 2% say that such a procedure exists. Thematic content analysis of our interviews revealed that no systematic way of transmitting geriatrician recommendations to PCPs exists, disrupting communication of medical information; a unified EMR can help; and confidentiality considerations are vital. Preliminary scoping review results show that various information transfer methods exist across different healthcare systems, from mailing to fax to electronic medical systems.

Discussion: Lacking a systematic process for information transfer to PCPs decreases the quality of healthcare for frail older adults. We hope to generate and disseminate actionable recommendations on effective strategies to improve this information transfer.

FINALISTS FOR THE RÉJEAN HÉBERT CANADIAN INSTITUTES OF HEALTH RESEARCH – INSTITUTE IN AGING PRIZE

Do Sex and Frailty Modify the Relationship Between Antidepressant Exposure and Dementia Risk: A Scoping Review

Lucy Eum[1], Pilar Robinson Gonzalez[1], Melissa K. Andrew[1], Sanja Stanojevic[1], Shanna Trenaman[1].
[1]Dalhousie University.

Background/Purpose: Depression is a modifiable risk factor for dementia. Prior studies on antidepressant use and dementia yielded conflicting results, potentially due to unmeasured confounders like sex and frailty. This review aimed to determine whether sex, frailty, or their interaction confound or modify this relationship in adults over 55.

Method: We searched PubMed, MEDLINE, Embase, CINAHL, and Cochrane Library databases. Eligibility criteria were revised during screening due to the lack of eligible studies and to reduce ambiguity. Studies were included if sex or frailty of participants was described.

Results: After screening 7803 titles/abstracts and 47 full texts, we included 21 observational studies. None explicitly defined or investigated sex or frailty as primary objectives, and no validated frailty measures were used. Of the 12 studies with significant sex/gender-based findings, 8 adjusted for sex along with other covariates, while 4 performed sex-specific analyses: one stratified by sex, one tested interaction terms, one stratified by sex and adjusted for only sex, and one stratified by sex and tested interaction terms. Stratification consistently showed higher dementia risk associated with antidepressant use in males than females. Adjustment for female sex attenuated the association in one study. Sex/gender binary frameworks dominated.

Discussion: The association between antidepressant use and dementia was inconsistent across the included studies. Stratified analyses tended to show that the association was

more pronounced in males, indicating that sex may be both a confounder and a modifier. Frailty confounding remains unexplored. Future research could incorporate validated frailty measures and explore sex and gender beyond binary definitions.

How Sex, Frailty, and Neuropathology Modify the Antidepressant-Dementia Relationship

Lucy Eum[1], Pilar Robinson Gonzalez[1], Melissa K. Andrew[1], Sanja Stanojevic[1], Shanna Trenaman[1].
[1]Dalhousie University.

Background/Purpose: Depression is a modifiable dementia risk factor often treated with antidepressants, but the long-term association between antidepressant use and Alzheimer's Disease (AD) risk remains unclear. This study examines the association between antidepressant exposure and AD and, whether binary sex, frailty, or neuropathology modify this relationship.

Method: This retrospective study analyzed data from 429 participants aged ≥55 with normal cognition, sourced from the Religious Orders Study (ROS) and the Memory and Aging Project (MAP). Frailty was measured using the frailty phenotype. The primary outcome was the association between antidepressant exposure and clinical diagnosis of AD. Secondary outcomes included potential modification by sex, frailty, or neuropathology index (NPI) scores. The NPI is a continuous variable based on 8 postmortem AD-related brain autopsy findings, and higher value indicates higher neuropathologic burden.

Results: Antidepressant exposure was statistically significantly associated with increased odds of AD (odds ratio (OR) 2.31, 95%CI: 1.51 – 3.57). The association was not modified by sex (OR for interaction 1.38, 95%CI: 0.50 – 3.91), frailty (OR for interaction 0.63, 95%CI: 0.30 – 1.29) or NPI (OR for interaction 2.08, 95%CI: 0.06 – 70.78).

Discussion: Antidepressant use was associated with increased odds of AD. The association was not modified by sex, frailty, or NPI. This study examined clinical diagnosis of AD as the outcome. Given the aging population and the need to identify modifiable risk factors of dementia, these findings highlight key insights for identifying more modifiable risk factors for dementia. Future studies could further explore the effect modification by using a frailty index.

Assessing the Geo-availability of Vaccination Sites for Nova Scotian Older Adults

Vincent Hou[1], Melissa K Andrew[2], Shanna C Trenaman[3], Daniel Rainham[4], Judith Godin[5].
[1]Department of Medicine, Faculty of Medicine, Dalhousie University; [2]Department of Medicine (Geriatrics), Dalhousie University, Canadian Centre for Vaccinology, Dalhousie University; [3]College of Pharmacy, Dalhousie University; [4]School of Health and Human Performance, Faculty of Health, Dalhousie University; [5]Geriatric Medicine Research, Dalhousie University.

Background/Purpose: Although vaccination is particularly important for older adults, access to vaccines may vary by geography. Urban areas often have more healthcare resources than rural regions, including vaccinations. Our study assesses the geo-availability of COVID and Influenza vaccination sites in Nova Scotia (NS), with particular attention to rural areas enriched in older adults.

Method: NS population data were obtained through the NS Department of Economics and Statistics website. COVID and influenza pharmacy immunization sites identified using the Pharmacy Association of NS database were used for spatial accessibility analysis. Pharmacies' postal codes were used to determine urbanicity. Pharmacy distribution was assessed by county in relation to older adult population distribution.

Results: As of July 2024, NS has a population of 1,056,486, with 22.5% being older adults aged 65+; 40% of the population resides rurally outside the two large municipalities. The median age is 44.2 years, with the median age being >10 years older in 12 rural counties, compared to Halifax, the youngest county. 274/313 pharmacies (87.5%) offer vaccinations, including 75/84 (89.3%) rural pharmacies. Guysborough County, with the oldest population, has three pharmacies in an area of 4037 km2.

Discussion: Rural communities with higher median age have few pharmacy vaccination sites. This inequity may perpetuate barriers to vaccination access for older adults living in rural areas, with increased transportation distance, time, and costs. Future studies should investigate how discrepancies in geographical accessibility affect vaccination rates for older adults and inform strategies to improve vaccination availability and uptake in rural areas.

InPAtient GuidElines for Responsive Behaviours (PAGER): A Scoping Review on Undifferentiated Responsive Behaviour Approaches in Older Adults in Acute Care Settings

Julian Li[1], Esther Su[2], Angela Luan[3], Kaitlin Adduono[4], Christina Reppas-Rindlisbacher[5], Justin Lee[1], David Cowan[1], Christopher Patterson[1], Eric Wong[5].
[1]McMaster University; [2]University of Sydney School of Medicine; [3]Queen's University; [4]Lakehead University; [5]University of Toronto.

Background/Purpose: There is no unified evidence-based approach to the care of older adults (65+) with undifferentiated responsive behaviours secondary to delirium, dementia or other conditions in acute care settings. Our objective was to summarize synthesis-level evidence regarding approaches to evaluation and management of these behaviours.

Method: We completed a scoping review of synthesis-level evidence examining approaches to diagnosis and management of undifferentiated responsive behaviours in older adults (65+)

in acute settings according to PRISMA-ScR guidelines and registered in Open Science Framework. Cochrane, Embase, Google Scholar, Medline, reference lists, and grey literature were systematically searched from January 1961 to January 2024. Title and abstract screening, full text review, and data abstraction were completed in duplicate.

Results: Of 5884 articles found, 275 full texts were reviewed, and 117 were included. Investigative and management approaches to undifferentiated responsive behaviours showed variability across five elements: healthcare disciplines, acute ward locations, etiology and contributing factors, behavioural characteristics, and management strategy. Evidence supported assessment tools for delirium but there was a paucity of tools for undifferentiated responsive behaviours. Management strategies encouraged multidisciplinary involvement, nonpharmacological interventions, and institutional approaches including healthcare provider education and policies. Pharmacological management strategies varied significantly across underlying etiology, health disciplines, and ward locations.

Discussion: Although delirium guidelines exist, there was limited consensus for a unified systematic algorithm to investigate and manage undifferentiated responsive behaviours. Further research is needed to guide the evaluation and management of undifferentiated responsive behaviours for older adults in acute settings.

Limb-holding Restraint Use in the Older Adult Population, a Scoping Review

Hannah Ramsay[1], Seung Heyck Lee[2], Allison Smith[3], Miriam Thake[4].
[1]Department of Medicine, University of Toronto, Ontario, Canada; [2]Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada; [3]Management Library, University of Ottawa; [4]Division of Geriatric Medicine, Department of Medicine, The Ottawa Hospital, Ontario, Canada.

Background/Purpose: To identify the breadth and depth of the existing evidence around limb-holding restraint use in the older adult inpatient population and map and synthesize this evidence to understand the harms and benefits of restraint use in this population to inform clinical decision-making.

Method: A scoping review of studies published in English reporting on limb-holding restraint use in older adult patients. A search strategy was developed in MEDLINE using a combination of key terms and subject headings related to older adults and physical restraints. Once peer-reviewed and finalized, the search strategy was translated to five other bibliographic databases and searched from inception to 2024. Two authors independently evaluated articles for inclusion, extracted relevant information, and mapped data on the harms and benefits of restraint use.

Results: Harms of limb-holding restraint use included injury, death, subsequent delirium, longer length of stay, and higher rates of behavioural, emotional and physical distress. While the rationale for using restraints was primarily based on the belief that they reduce the risk of self-harm and harm to others, there was no conclusive evidence supporting any tangible benefits of limb-holding restraint use. Additionally, numerous studies emphasized the discomfort experienced by healthcare practitioners, particularly nursing staff, when applying restraints.

Discussion: There is no evidence to support the use of limb-holding restraints among older adult inpatients. Future studies aimed at reducing restraint use should integrate implementation science frameworks, engage interdisciplinary teams, and include the perspectives of patients and their families.

FACULTY PODIUM PRESENTATIONS

How Often and Why Residents from Assisted Living Facilities Visit the Emergency Department

Pamela Jarrett[1], Susan Benjamin[2], Karla Faig[1], Jennifer Peterson[1], Liam Breckenridge[1], Sherry Gionet[1], Donaldo Canales[1], Patrick Feltmate[1], Paul Atkinson[3], Susan Benjamin[2], Susan Brien[1], Tara Stewart[1], Pamela McDougall[1], Greg Doiron[1], Grant Handrigan[4], Mark Wies[5], Mary Williams[6], Alesha Gaudet[7], Diane Lirette[8], Ginette Pellerin[9], Sandra Magalhaes[10], Barry Strack[1], Kavish Chandra[1].
[1]Horizon Health Network; [2]Trauma New Brunswick; [3]Dalhousie Medicine New Brunswick; [4]Université du Moncton; [5]New Brunswick Special Care Home Association; [6]Department of Health Province of New Brunswick; [7]Department of Social Development Province of New Brunswick; [8]New Brunswick Extra-Mural Program; [9]Medavie Health Services New Brunswick; [10]University of New Brunswick.

Background/Purpose: An increasing number of older adults are residing in assisted living facilities or special care homes (SCH), who have complex medical, physical and psychiatric illnesses requiring care and assistance with daily living. Previously, we found these residents have high emergency department (ED) utilization. Our objective was to describe utilization among SCH residents at Regional Hospital EDs (RH-ED) in New Brunswick.

Method: We conducted a retrospective cohort study by chart review of adults 65 years or older from a SCH who presented to a RH-ED between January 1 to December 31, 2023. We collected demographic data, reason for visit and other clinical data including ED diagnosis and discharge disposition.

Results: There were 1586 RH-ED visits made by 824 SCH residents (1.9 visits/SCH resident), representing nearly a quarter (23.4%) of SCH residents. Most (81.3%) arrived by ambulance, between 0800h and 1600h (47.3%), with a Canadian Triage and Acuity Score (CTAS) Level of 2 (37.9%)

or 3 (48.0%), most commonly for falls (19.0%) or infection (16.8%), with 43.5% requiring admission.

Discussion: This provides a description of the RH-ED visits made by SCH residents, an under reported population in the literature. Many SCH residents utilize the RH-ED in a year, with 4-5 residents visiting a RH-ED each day. A large proportion of the visits were CTAS 3, suggesting an opportunity to reduce ED utilization. Additional research is needed to better understand the factors related to ED utilization and provide insight into these visits and how utilization of RH-ED compares to that of Nursing Home residents.

Increasing Healthcare Providers' Knowledge and Confidence in Driving Cessation and Dementia through an Online Educational Program

Gary Naglie[1], Elaine Stasiulis[2], Anna Byszewski[3], Isabelle Gélinas[4], Chris Pilieci[2], Donna Ruffo[5], Sarah Traynor[6], Brenda Vrkljan[7], Charlene Welsh[8], Mark J Rapoport[9].
[1]Baycrest Health Sciences, University of Toronto; [2]Baycrest Health Sciences; [3]University of Ottawa; [4]McGill University; [5]North York General Hospital; [6]Trillium Health Partners; [7]McMaster University; [8]West Durham Family Health Team; [9]Sunnybrook Health Sciences Centre, University of Toronto.

Background/Purpose: While healthcare providers (HCPs) play a crucial role in supporting people with dementia (PWD) through the driving cessation process, many do not feel equipped with the tools, knowledge, or confidence to do so. We developed an online education program to address this gap. Our objective was to assess the impact of this program on HCPs' knowledge and confidence and determine factors predicting impact.

Method: The sample included 7 physicians, 65 occupational therapists, 19 nurse practitioners, and 15 students/trainees. Participants were assessed on 13 pre-post outcomes: 6 regarding knowledge and 7 regarding confidence. Another 3 factors were assessed as predictors: years of practice, practice type, and prior access to the Driving and Dementia Roadmap (DDR). Data were analyzed using Wilcoxon Signed-Rank tests and multiple logistic regressions.

Results: Significant pre-post improvements were found for all knowledge (Cohen's r = 0.54-0.79) and confidence (Cohen's r = 0.53-0.76) outcomes ($p<.05$). Years of practice predicted 5 outcomes, practice type predicted 2 outcomes, and prior access to the DDR predicted 2 outcomes ($p<.05$). The most consistent predictor was years of practice, as those with fewer years experienced a greater odds (OR = 4.07-5.30, $p<.05$) of improvement.

Discussion: This online education program significantly impacted HCPs' knowledge and confidence in supporting PWD through driving cessation. HCPs with fewer years of practice experienced the greatest impact. This online program can be helpful in equipping HCPs, especially those in the early stages of practice, with the knowledge and confidence to support PWD through this complex transition in their lives.

Barriers and Facilitators to Preoperative Comprehensive Geriatric Assessments of Older Adults Undergoing Surgery: A Semi-structured Interview Study of Patient and Care Partner Perspectives

Krista Reich[1], Cady Woo[1], Paula Horsley[2], Shannon Ruzycki[1], Stacey Hall1, Greg Samis[1], Sid Shinde[1], Rohan Lall[1], Michelle Mah[3], Gloria Wilkinson[4], Deepa Acharya[4], Rachel Khadaroo[2], Adrian Wagg[2], Jayna Holroyd-Leduc[1], Zahra Goodarzi[1].
[1]University of Calgary, [2]University of Alberta, [3]Alberta Health Services, [4]Patient and Family Centred Care.

Background/Purpose: Comprehensive geriatric assessments (CGA) improve outcomes of older adults undergoing surgery. However, few older adults receive CGA before surgery in Alberta. We aim to identify the barriers and facilitators to evidence-based surgical care practices for older adults and to preoperative CGA from the perspective of patients and care partners.

Method: We conducted semi-structured interviews of older adults undergoing noncardiac surgery and their care partners in Calgary, Alberta using the theoretical domains framework (TDF). We analyzed data in two stages: framework analysis and deductive coding to the TDF that links to the Behavior Change Wheel to identify interventions that can address barriers to implementation.

Results: We included 11 patients and 2 care partners. We identified 4 barriers and 3 facilitators. The barriers included lack of knowledge on the specialty of Geriatric Medicine and geriatric preoperative care practices, lack of time with surgical teams to discuss risks and benefits of surgery, negative experiences with long surgical wait times, and lack of advance care planning. The facilitators include positive views of geriatric preoperative assessments, acceptance of additional assessments with a geriatrician to improve outcomes, and information about geriatric interventions can help patients advocate for these assessments. These mapped to the TDF domains of knowledge, beliefs about capabilities, optimism, memory, attention, and decision processes, and environmental context and resources.

Discussion: Older adults undergoing surgery and their care partners see a role for preoperative CGA, but we must tailor implementation of evidence-based care practices and preoperative CGA for older adults based on identified barriers and facilitators.

Expanding Team-based Care for Frail Older Adults: A New Model Of Care

Carla Rosario[1], Einat Danieli[2], Joshua Waks[3], Kaitlin Siou[1], Jagger Smith[4].
[1]Baycrest Health Sciences, Department of Medicine, University of Toronto; [2]Clinical Manager, Ambulatory Care, Toronto North Interprofessional Primary Care Team; [3]Futurity Medical, 4Baycrest Hospital.

Background/Purpose: Older adults living with frailty are complex and require a team-based approach to care. In The North Toronto OHT, only 7% of patients have a primary care provider who has access to an interprofessional team. Similarly, most Geriatric Medicine clinics do not have a full interprofessional teams. Our objective was to co-design a model-of-care for frail older adults, integrating existing resources in support of community-based family doctors and Geriatricians that do not have access to an interprofessional team.

Method: Current-state and needs-assessment analysis were done. An Electronic Frailty Index algorithm was used to screen all patient's from one family physician's practice, stratifying older adult patients into mild, moderate, and severely frail categories. The family doctor manually checked all patients with moderate frailty (n=48). Using co-design strategies, all partners in this model optimized a seven-step pathway reflective of integrated care. The family physician worked with a mobile interprofessional team and a Geriatrician to assessed moderate frailty patients in the family physician's office. PDSA cycles were used for rapid cycles of improvement.

Results: There were forty-eight moderately frail patients. Using our model, from fifteen patients so far, twelve had their geriatric syndromes reviewed without the need to see a Specialist; four were escalated to see a Geriatrician which was done in the family doctor's office, documented in their EMR.

Discussion: Our model supports interprofessional team work to optimize patient and caregiver experience by bringing Geriatric Medicine assessments to the family doctor's office. It also helps select the most appropriate patients for Geriatric Medicine consultations.

Family Caregiver Distress, Nursing Home Placement and Psychotropic Drug Prescribing Among Care Recipients Living with Dementia: A Population-based Propensity-matched Study in Ontario, Canada

Nathan Stall[1,2,3], Vasily Giannakeas[2,4,5], Kristina Kokorelias[1,6], Andrea Gruneir[7,8], Lisa Lix[7], Kieran Quinn[1,3,5,9], Lesley Wiesenfeld[10,11], Christina Reppas-Rindlisbacher[1,2,3,9], Michael Hillmer[9,12], Chaim Bell[1,3,5,9], Paula Rochon[1,2,3,5,9].
[1]Division of General Internal Medicine and Geriatrics, Sinai Health System and the University Health Network, Toronto, Canada; [2]Women's Age Lab and Women's College Research Institute, Women's College Hospital, Toronto, Canada; [3]Department of Medicine, University of Toronto, Toronto, Canada; [4]Dalla Lana School of Public Health, University of Toronto, Toronto, Canada; [5]ICES, Toronto, Canada; [6]Department of Occupational Sciences and Occupational Therapy, Temerty Faculty of Medicine, University of Toronto, Toronto, Canada; [7]Department of Community Health Sciences, University of Manitoba; [8]Department of Family Medicine, College of Health Sciences, University of Alberta, Edmonton, Alberta, Canada; [9]Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada; [10]Department of Psychiatry, University of Toronto, Toronto, Canada; [11]Division of Psychiatry, Sinai Health System, Toronto, Canada; [12]Digital and Analytics Strategy, Ministry of Health, Toronto, Canada.

Background/Purpose: Many people living with dementia (PLWD) are supported by unpaid family caregivers. We evaluated the association between caregiver distress and nursing home (NH) placement and psychotropic drug prescribing among care recipients living with dementia.

Method: Population-based cohort study of PLWD aged ≥66 years who were receiving home care and had ≥1 family caregiver. We used linked databases held at ICES and included PLWD assessed with the RAI-HC tool (index date) between 2010–2021. Our exposure was caregiver distress identified on index home care assessment. Our primary outcomes were care recipient NH placement and psychotropic drug prescribing. Our secondary outcomes were care recipient all-cause mortality, emergency department (ED) visits and hospitalizations. We generated a propensity score for caregiver distress and matched PLWD with distressed caregivers to those without distressed caregivers. We followed PLWD for 365 days after index date or until death.

Results: Among 130,416 older PLWD receiving home care (57.9% female; median age 84.0 years), 56,929 (43.7%) had distressed family caregivers. Between 2010–2021, the prevalence of caregiver distress increased from 32.4% to 58.9%. In the matched cohort of 39,092 PLWD, those with distressed caregivers were 34% more likely to be placed in a nursing home (HR=1.34; 95%CI=1.30–1.38) and 7% more likely to be prescribed psychotropic drugs (RR=1.07; 95%CI=1.03–1.10). Caregiver distress was not associated with significant increases in care recipient mortality, ED visits or hospitalizations.

Discussion: Family caregivers for older PLWD experienced a near doubling of caregiver distress between 2010-2021. Caregiver distress was associated with increased NH placement and psychotropic drug prescribing among PLWD.

Comparative Efficacy of Interventions for Reducing Depressive Symptoms and Burden in Family and Friend Caregivers of People Living with Dementia: A Systematic Review and Network Meta-analysis

Jennifer Watt[1], Zahra Goodarzi[2].
[1]*University of Toronto,* [2]*University of Calgary.*

Background/Purpose: Family and friend caregivers of people living with dementia (PLWD) experience higher distress than other caregivers, yet receive limited resources beyond dementia-related education.

Method: We searched MEDLINE, Embase, CENTRAL, CINAHL, PsycINFO, and grey literature from inception until June 13, 2024, for randomized trials (RCTs) comparing any intervention's efficacy to usual care or any other intervention for reducing depressive symptoms or burden in PLWD's family or friend caregivers. Independent reviewer pairs conducted study screening, data abstraction, risk of bias appraisal, and GRADE assessments. We derived standardized mean differences that were transformed to mean differences (MD) on the 20-item Center for Epidemiologic Studies Depression Scale and 22-item Zarit Burden Interview, and probabilities of exceeding CES-D's and ZBI's minimum clinically important difference (pMCID), from Bayesian random-effects network meta-analysis (NMA).

Results: We included 173 RCTs (70 interventions, 23828 caregivers). Caregiver education, psychotherapy and support (MD -34.7, 95% credible interval -24.1 to -45.6; pMCID 100%; moderate certainty); caregiver education and training (-3.5, -1.1 to -5.9; 28.4%; moderate certainty); caregiver education and psychotherapy (-11.7, -1.3 to -22.0; 92.0%; low certainty); caregiver mindfulness and meditation (-4.5, -0.2 to -8.9; 56.0%; moderate certainty); and caregiver education, journaling and psychotherapy (-7.0, -0.6 to -13.6; 80.2%; high certainty) were more efficacious than education for reducing depressive symptoms; caregiver education and training (-6.5, -0.9 to -12.0; 58.5%; moderate certainty) was more efficacious than caregiver education for reducing burden.

Discussion: Training and mental health therapies, with or without education, were more efficacious than education alone at improving mental health of PLWD's family and friend caregivers.

FINALISTS FOR THE DR. JACK & DR. ASA AWARD

Improving Geriatric Assessment Efficiency: A Qualitative Analysis of Collaborator Perspectives

Manan Ahuja[1], Margaret Moran[2], Junghyun Park[1].
[1]*Department of Geriatric Medicine, McMaster University, Hamilton, ON, Canada, Hamilton Health Sciences;* [2]*Hamilton Health Sciences.*

Background/Purpose: The aging Canadian population has increased the demand for specialized geriatric services, but a shortage of skilled professionals poses significant challenges. At the Centre for Healthy Aging in Hamilton, Ontario, prolonged cycle times for initial geriatric assessments have limited clinic capacity. A parent project using lean methodology successfully reduced patient assessment times from 114 to 93 minutes for one geriatrician's clinic by implementing a shared electronic medical record note for healthcare providers and a targeted cognitive testing assessment guide. This substudy sought to evaluate collaborator feedback after spread of change ideas to the entire clinic.

Method: One month post implementation, semi-structured interviews were conducted with key collaborators, including Geriatricians, Case Managers (Occupational Therapists and Registered Nurses), and Registered Practical Nurses (RPNs). Interviews were conducted and transcribed by a research volunteer. The anonymized interviews were analyzed using inductive thematic analysis by two independent reviewers to identify common themes.

Results: Qualitative analysis of interviews from five Geriatricians, five Case Managers, and two RPNs revealed five key themes: 1) communication gaps, 2) perspectives on documentation standardization, 3) learning readiness, 4) effects on workflow, and 5) lack of clarity regarding roles and responsibilities.

Discussion: Collaborator feedback highlighted both successes and ongoing challenges in implementing workflow changes to improve geriatric assessment efficiency. Addressing communication gaps, role ambiguity, and readiness for change through targeted training and improved processes is critical for sustaining improvements. These findings underscore the importance of iterative, collaborator-informed approaches in optimizing care delivery for an aging population.

Nutritional Status Is Associated with Physical Performance of Hospitalized Older Adults

Tevy Chan[1], Nicole Aswad[2], Arianne Zabbal[2], Felipe Broering[2], Guy Hajj-Boutros[2], Stéphanie Chevalier[1], José Morais[1].
[1]*McGill University;* [2]*Research Institute - McGill University Health Centre.*

Background/Purpose: Malnutrition is a common but often underrecognized problem within the geriatric population. This study aims to assess the nutritional status of hospitalized older adults and evaluate its association with physical and functional performance.

Method: We consecutively recruited 30 adults ≥75 years admitted to medicine at the MUHC-Montreal General Hospital. Nutritional status was assessed using the Global Leadership Initiative on Malnutrition(GLIM) criteria and the Mini Nutritional Assessment-Short Form(MNA-SF). Anthropometric

measurements were performed. Physical performance was assessed with Short Physical Performance Battery(SPPB), gait speed and handgrip strength, and functional performance with the Barthel Index. Linear model explored the relationship between nutritional status and the physical and functional outcomes. Covariates included age, sex and disease burden using the Cumulative Illness Rating Scale(CIRS).

Results: The participants' median age was 83 (range 75-94 years), 66%female. Their median pre-admission clinical frailty scale was 6. Median number of comorbidities was 7(0-12). Median CIRS score was 13(3-28). Among participants, 28% had moderate malnutrition and 31% severe malnutrition as per GLIM. After adjusting for covariates, individuals classified as malnourished on GLIM had lower SPPB scores compared to those with normal nutrition (β= -1.89,p=0.016), similarly for MNA-SF (β= -1.61, p=0.04). Moderate and severe malnutrition (GLIM) were associated with slower gait speed (β= -0.25m/s, p=0.002). No association was found for handgrip strength or Barthel index.

Discussion: Physical performance significantly correlated with the nutritional status of inpatient older adults. Using simple and routine nutritional assessment tools can aid in identifying individuals with poor physical performance and support the management of high-risk patients.

Older Adults with a Fall-Related Hospitalization and Subsequent Hip Fracture - an Ontario Retrospective Cohort Analysis

Benoit Lafleur[1], Wenshan Li[2], Reiko Okamoto[2], Edward Spilg[1].
[1]University of Ottawa; [2]Ottawa Hospital Research Institute.

Background/Purpose: There is a literature gap in identifying older adults at risk of a hip fracture after a fall-related hospitalization. We aimed to compare the characteristics, outcomes, and intervention use of older adults hospitalized following a fall, and identify factors associated with increased hazard of having a subsequent hip fracture within 2 years of discharge.

Method: We performed a retrospective cohort analysis of all Ontarians aged 65+ hospitalized following a fall from 2015/11/01-2020/10/31 using administrative health databases. We compared individuals who did or did not experience a hip fracture within 2 years of discharge based on socio-demographics, frailty, comorbidities, and receipt of DXA scan, family physician, or geriatrician visit. We performed Cox-Proportional regression to identify factors associated with having a subsequent hip fracture, accounting for death as a competing risk.

Results: Approximately 4.5% (N = 3946) of older adults with a fall-related hospitalization suffered a hip fracture within 2 years of discharge (average 305 days [SD=214]). Factors that increased the hazard of having a hip fracture were increasing age (hazard ratio [HR] 1.04, 95% confidence interval [CI] 1.04–1.05), being female (HR 1.16, CI 1.08–1.24), parkinsonism (HR 1.42, 1.19–1.70), dementia (HR 1.28, 1.17–1.41), a mental health disorder (HR 1.10, 1.01–1.20), or intermediate frailty (HR 6.68, 3.28–13.7). Those who received a DXA scan post-discharge were ~25% less likely (HR 0.75, 0.66–0.86) to sustain a subsequent hip fracture.

Discussion: Timely fall risk reduction and bone health optimization should be targeted towards most at-risk groups noted above.

Managing Sexual Expressions of Potential Risk in Adults with Major Neurocognitive Disorders: A Systematic Review of Pharmacologic and Non-Pharmacologic Strategies

Natasha Lane[1], Manan Ahuja[2], Stacey Hatch[3], Jessie McGowan[4], Dallas Seitz[3], Jennifer Watt[1].
[1]University of Toronto Division of Geriatric Medicine; [2]McMaster University Division of Geriatric Medicine; [3]University of Calgary; [4]University of Ottawa.

Background/Purpose: Sexual expressions of potential risk – such as sexual touching and sexual exposure – occur in up to 25% of people with major neurocognitive disorder. This systematic review examines the effectiveness of pharmacologic and non-pharmacologic interventions to manage sexual expressions of potential risk in older adults with major neurocognitive disorders.

Method: We searched MEDLINE, APA PsychInfo, Embase, JBI EBP Database, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews and Ageline databases, with no limits on study date or language, from inception until September 8, 2023. All study designs were eligible for inclusion if they examined adults with major neurocognitive disorder and inappropriate sexual expression who were subject to pharmacologic or non-pharmacologic intervention, with changes in sexual expression post-intervention reported. Two reviewers independently completed all study screening, data abstraction and risk of bias assessments.

Results: We identified 1,445 unique citations, reviewed 161 in full text, and included 74 in the narrative synthesis, of which 60 were case studies and 12 were case series. Most studies were at high risk of bias. Hormonal treatments, including progestins and anti-androgens, led to improvement or resolution of inappropriate sexual expression more frequently than antipsychotics, antidepressants, or anticonvulsants. Effective non-pharmacologic strategies included distraction, patient and family education and environmental modifications.

Discussion: No high-quality evidence was identified to guide the management of sexual expressions of potential risk in adults with major neurocognitive disorders. Randomized trials studying the effectiveness, safety and implementation of pharmacologic and non-pharmacologic interventions are needed to guide practice in this area.

Sex Differences in Home Care Responsiveness to Hospitalization Among Older Home Care Clients in Nova Scotia and Winnipeg Regional Health Authority

Lori Lori Mitchell[1], Jeffrey Poss[2], Jasmine Mah[3], Susan Stevens[4], Janice Keefe[4].
[1]Shared Health Manitoba CA; [2]University of Waterloo; [3]Dalhousie University; [4]Mount Saint Vincent University.

Background/Purpose: Older adults often require discharge support to return home safely, yet little is known about how home care programs respond to client hospitalization. We examined sex differences in home care service hours pre- and post- hospitalization for home care clients aged 60+ in Nova Scotia (NS) and Winnipeg Regional Health Authority (WRHA).

Method: Retrospective analyses were conducted using linked data from the Resident Assessment Instrument, administrative data and Discharge Abstract Database. Clients received publicly funded home care in 2011-2013 and were followed for up to four years. We conducted sex stratified and disaggregated bivariate and multivariate linear regression models of the responsiveness (change) in home care hours.

Results: In NS, 1024/5323 and in WRHA, 898/5278 clients had non-elective hospitalizations during their first year of follow up and were discharged with home care. Average pre-hospitalization hours were 5.90 in NS and 5.01 in WRHA (p=0.005) compared with post-hospitalization hours of 8.85 and 7.26 (p<001) respectively. There were more females (66.2%) in NS than WRHA (60.5%) (p=0.009). In NS, dependence for toileting was associated with greater home care responsiveness among males. In WRHA, limited education, Parkinson's disease and dependence for toileting and transferring were associated with positive home care responsiveness for females as was hospital alternate level of care status for males even after adjusting for marital status or clients with co-residing caregivers.

Discussion: Overall, home care hours increased following hospitalization although there were significant sex differences and regional variations. Recognizing these differences have implications for the organization of publicly funded home care programs.

Evaluating pQCT as an Alternative to MRI for Detecting Loss of Muscle Mass Following 14 Days of Bedrest in Middle-age to Older Adults

Laura Miles[1], Andréa Faust[2], Vita Sonjak[1], Guy Hajj-Boutros[1], José A. Morais[1].
[1]McGill University; [2]Jewish General Hospital.

Background/Purpose: Prolonged mechanical unloading, such as during extended bed rest or spaceflight (microgravity), leads to significant loss of muscle mass. This study compared peripheral quantitative computed tomography (pQCT) with magnetic resonance imaging (MRI) to assess muscle loss after 14 days of head-down tilt bedrest (HDBR), an Earth model of microgravity.

Method: Twenty-two participants (mean± SD: 59 ± 3 years; 24.9 ± 3 kg/m²) underwent 14 days of HDBR with (n=11) or without (n=11) exercise as a countermeasure. Thigh and calf cross-sectional areas were assessed using pQCT and MRI before and after the intervention.

Results: All participants experienced significant weight loss: -1.2 [-1.9, -0.5] kg in the exercise group and -1.1 [-1.6, -0.6] kg in the control group following the intervention. MRI revealed a significant protective effect of the exercise intervention on muscle loss. Thigh muscle reductions were -3.9 ± 2.2 cm² (control) versus -0.5 ± 1.2 cm² (exercise), and calf losses were -3.6 ± 2.0 cm² (control) versus -2.8 ± 0.9 cm² (exercise) (all, p<0.05). pQCT results showed similar trends, with thigh losses of -1.9 ± 1.6 cm² (control) versus -0.2 ± 2.5 cm² (exercise), and calf losses of -4.0 ± 2.9 cm² (control) versus -3.2 ± 4.7 cm² (exercise) (all, p<0.05).

Discussion: Both MRI (gold standard) and pQCT (cost-effective alternative) are effective for assessing muscle volume loss during bedrest. The exercise protocol demonstrated a protective effect, offering insights for interventions for bedridden patients or inflight countermeasures for astronauts, while emphasizing the need to explore exercise's protective mechanisms further.

FINALISTS FOR THE EDMUND V. COWDRY AWARD

'They're Looking for More Answers Than I Can Give!': A Qualitative Study Exploring Clinicians' Needs in Medical Cannabis Decision Support

Heba Aref[1], Yazid Al Hamarneh[2], Elaine Yacyshyn[3], Tony Kiang[4], Cheryl Sadowski[1].
[1]University of Alberta; [2]Faculty of Medicine and Dentistry, University of Alberta; [3]Faculty of Medicine & Dentistry—University of Alberta; [4]Faculty of Pharmacy & Pharmaceutical Sciences—University of Alberta.

Background/Purpose: The medical use of cannabis for arthritis has increased, with nearly half of individuals with arthritis aged 65 and older. Clinicians often encounter patients seeking guidance—either about current use or considering initiation. As patients rely on clinicians for support, this study explores the resources clinicians need to assist patients in cannabis decision-making.

Method: This qualitative descriptive study recruited clinicians who treated patients with arthritis. Purposive and snowball sampling were employed. Eligible participants were practicing clinicians who received patient inquiries regarding medical cannabis. Data were collected via semi-structured Zoom interviews, transcribed verbatim, and analyzed iteratively to remain closely aligned with participants' perspectives.

Results: A total of 11 participants were recruited (37% pharmacists, 27% family physicians, 27% rheumatologists, and 9% registered nurses). Participants ranged in age from 29 to 69 years and had one to 50 years of clinical practice experience. Clinicians reported that patients seek more answers about cannabis than they can provide. Three key themes were determined describing clinicians' decisional needs. Those needs were: (1) robust, non-biased evidence, (2) training programs, and (3) policy changes to regulate medical cannabis.

Discussion: The lack of robust evidence on cannabis limits clinicians' ability to support older adult patients with arthritis. Participants emphasized the need for unbiased evidence, including randomized controlled trials and longitudinal studies. They also called for targeted training on current evidence and advocated for policy changes to standardize cannabis production. These findings underscore the importance of dialogue among clinicians, patients, and policymakers to facilitate effective, shared decision-making on cannabis use for arthritis symptoms.

Defining Physician Commitment in Long-Term Care Homes: Results from a Modified e-Delphi Study

Darly Dash[1], Maya Potter[2], Henry Siu[3], Patrick Quail[4], Lisa McCarthy[5], Paul Katz[6], Paula Rochon[7], Aaron Jones[1], Andrew P Costa[1], Nathan M Stall[2].
[1]Health Research Methods, Evidence, and Impact, McMaster University, Hamilton, Canada, [2]Geriatrics, Sinai Health, Toronto, Canada, Medicine, University of Toronto, Toronto, Canada, [3]Family Medicine, McMaster University, Hamilton, Canada, [4]Family Medicine, University of Calgary, Calgary, Canada, [5]Pharmacy, University of Toronto, Toronto, Canada, [6]Geriatrics, Florida State University, Tallahassee, USA, Medicine, McMaster University, Hamilton, Canada, [7]Women's Age Lab, Women's College Hospital, Toronto, Canada.

Background/Purpose: The delivery of physician care varies across long-term care (LTC) homes. While physician commitment is proposed as a predictor of quality in LTC, there is no agreed-upon definition. This study used consensus-building methods to define physician commitment in Canadian LTC.

Method: We conducted a two-round modified e-Delphi study (registration #ISRCTN35125526) with Canadian LTC physicians, and a virtual consensus meeting between rounds. In each e-Delphi round, panellists rated items on two evaluative criteria (relevance and feasibility) on a 7-point scale and provided qualitative feedback. The meeting between rounds discussed areas of non-consensus and modifications required. Consensus was defined as ≥70% of the panel rating an item in a particular direction. Quantitative and qualitative data were analyzed for each item.

Results: We identified 38 items and recruited 27 LTC physicians (average age=53 years; average years of LTC practice=17.6 years; 63% female; 22% rural practices). In round one, 18 items reached consensus as relevant and feasible for LTC physician commitment. In round two, 22 items were re-rated that did not reach consensus (worded as-is or rephrased for clarity) and included new items as suggested by the panellists. The following concepts were selected to be included in a definition of commitment: time spent in LTC, in-person visits, residents cared for, working with the team, medication management, documentation, and palliative and end-of-life care.

Discussion: The endorsed items on LTC physician commitment provide a clear, evidence-informed definition that will enhance our ability to better characterize and quantify physician involvement in this care setting.

Prevalence of Dementia Among Adults Who Have Experienced Homelessness, A Systematic Review and Meta-Analysis

Peter Hoang[1], Jillian Alston[1], Vivian Braithwaite[2], Yu Qing Huang[1], Mohammad Jay[1], Courtney van Ballegooie[2], Christina Reppas-Rindlisbacher[1], Natasha Lane[1], Paula Rochon[1].
[1]University of Toronto; [2]University of British Columbia.

Background/Purpose: Understanding the prevalence and risk of dementia in adults experiencing homelessness has important implications for ensuring appropriate resources are directed towards equitable healthy aging. We aimed to estimate the prevalence and risk of dementia in adults experiencing homelessness.

Method: We searched MEDLINE, PsycINFO, Embase, CINAHL, Cochrane Central, Social Works Abstracts and the grey literature from inception to September 26, 2024. Studies investigating the prevalence of dementia among individuals experiencing homelessness aged 18 or older were included. Title, abstract and full text screening, extraction, and risk of bias assessments were completed in duplicate. Random effects meta-analysis was used to estimate the prevalence and risk of dementia.

Results: A total of 1585 citations were retrieved, with 102 studies undergoing full-text review and 35 studies included in the final review (504,614 individuals experiencing homelessness, weighted mean age 63.08, female percentage 10.64. The prevalence of dementia was 6.99% (95% CI 4.56, 10.54 %, I2 = 99.8%). Among those who experienced homelessness, compared to housed individuals, the unadjusted risk ratio for dementia was 1.03 (95% CI 0.51, 2.09, I2 = 99.7%), while the incidence (hazard ratio) for dementia was 1.54 (0.52, 4.50, I2 = 98.0%).

Discussion: This systematic review and meta-analysis suggests that homeless individuals have an earlier onset of dementia compared to the general population, with a higher prevalence than the population average of those under 65. Future research should identify the typology of homelessness and subtype of dementia, and describe how dementia may be implicated in the risk of homelessness and vice versa.

Dementia Rate and Care Needs in Older Adults with Traumatic Brain Injury and Intersections with Social Determinants of Health: A Population-based Cohort Study

Jennifer Ann Watt[1], Manav Vyas[2], Alan Ka Ho Tam[3], Yu Qing (Jenny) Huang[1], Sharon Elizabeth Straus[1], Zhiyin Li[4], Jun Guan[4], Peter Hoang[1], Corita Vincent[1], Mark Bayley[1], Susan Bronskill[4].
[1]University of Toronto, [2]St-Michael's Hospital, Toronto, Ontario, [3]Division of Physical Medicine & Rehabilitation, University of Toronto, [4]ICES.

Background/Purpose: Quantifying the association between dementia, care needs, and traumatic brain injury (TBI) sustained in older adulthood is required to address gaps in care. We evaluated these outcomes and their associations with social determinants of health (SDoH) to inform tailored care strategies.

Method: Using administrative data in Ontario, Canada, our matched retrospective cohort included community-dwelling individuals aged 66 years and older who sustained a TBI between April 1, 2004, and March 1, 2020, with follow-up until March 1, 2021. Individuals with TBI were matched 1:1 to individuals without TBI based on age, sex and clinically-derived propensity score. Cause-specific hazard models were constructed for outcomes including dementia, home care use and long-term care home (LTCH) admission. Conditional inference trees were used to identify subgroups at high risk for these outcomes based on associations with SDoH.

Results: We included 132,113 individuals with TBI. TBI was associated with a higher rate of short-term (hazard ratio [HR] 1.69, 95% confidence interval [CI] 1.66-1.72) and long-term (HR 1.56, 95% CI 1.53-1.59) dementia, home care use (HR 1.30, 95% CI 1.29-1.31) and LTCH admission (HR 1.45, 95% CI 1.42-1.47). Older females with TBI from low-income neighbourhoods had a higher probability (29%) of dementia than males (24.7%). Rural residents were less likely to receive home care but more likely to be admitted to LTCHs if they were also from low-income and less diverse areas.

Discussion: TBI in community-dwelling older adults was associated with a higher rate of dementia, home care use and LTCH admission; SDoH were predictors of these outcomes.

Barriers and Facilitators in Seeking Community-based Dementia Care Provided by Regulated Healthcare Professionals in Racialized Older Adults: An Integrative Literature Review

Florence Paat[1], Shirin Vellani[2], Katherine McGilton[3], Martine Puts[4].
[1]Trillium Health Partners; [2]Toronto Rehabilitation Institute–University Health Network; [3]KITE Research Institute–Toronto Rehabilitation Institute (UHN); [4]Princess Margaret Cancer Centre–University Health Network.

Background/Purpose: Racialized older adults remain underrepresented in dementia-related healthcare services. Currently, there is over half a million people in Canada who live with dementia and with advanced age being a risk factor for dementia, it is anticipated that dementia will impact almost a million Canadians by 2030, many of whom belonging to diverse background. This review aimed to explore the barriers and facilitators to seeking community-based dementia care provided by regulated healthcare providers in racialized older adults from the perspectives of clinicians and caregivers.

Method: An integrative review of the literature was conducted. Databases included MEDLINE, EMBASE and EBSCOhost CINAHL Plus. The Socioecological Model of Health framework was used to categorize the identified themes. The review included 7 qualitative and 2 mixed methods studies.

Results: The findings related more to the barriers in accessing dementia care. Six themes emerged: (1) knowledge and awareness related to dementia diagnosis and care; (2) distrust in HCP; (3) language barrier; (4) cultural competencies and beliefs; (5) healthcare infrastructure; and (6) community resources and support. The review was limited by the small number of studies available.

Discussion: The findings revealed a need to better understand the experiences of racially diverse communities when accessing dementia care. There is a need to develop culturally appropriate programs and resources tailored to the needs of racialized older adults living with dementia and their caregivers and care partners. Further research is warranted to explore the topic to inform future interventions and policy development.

Associations Between Mild Behavioural Impairment-Apathy and Plasma p-Tau Levels

Daniella Vellone[1], Zahinoor Ismail[1].
[1]University of Calgary.

Background/Purpose: Mild Behavioural Impairment (MBI), characterized by later-life emergent and persistent neuropsychiatric symptoms (NPS), is a risk factor for cognitive decline and dementia. Among its domains, apathy is particularly associated with Alzheimer's disease (AD) pathology. This study investigates cross-sectional and longitudinal associations between MBI-apathy and plasma phosphorylated tau (p-tau) levels using Alzheimer's Disease Neuroimaging Initiative (ADNI) data.

Method: We analyzed 396 participants (mean age = 72.5 years; 41.4% cognitively normal, 49.5% female), categorized into three groups: No NPS (n = 215), NPS not meeting MBI criteria (NPS-not-MBI) (n = 112), and MBI-apathy (n = 69). Cross-sectional analyses used linear regression models, with plasma p-tau as the outcome and NPS status as the predictor adjusting for age, sex, education, cognitive diagnosis, APOE4 status, and NPS assessment type. Longitudinal analyses used linear mixed-effects models at two and three years,

incorporating interaction terms for NPS status and time as well as cognitive diagnosis and time.

Results: MBI-apathy was associated with higher plasma p-tau levels cross-sectionally ($\beta = 26.34$; 95% CI = 3.37–54.43; $p = 0.02$) and longitudinally at two years ($\beta = 36.63$; 95% CI = 9.57–70.38; $p = 0.006$) and three years ($\beta = 39.11$; 95% CI = 10.89–74.52; $p = 0.005$). NPS-not-MBI status was not significantly associated with p-tau levels at any time point.

Discussion: These findings suggest that MBI-apathy may reflect underlying AD pathology and could serve as a potential biomarker for disease progression. Further research is needed to investigate the mechanisms linking MBI-apathy to tau pathology to refine early intervention strategies.

POSTERS

An Environmental Scan of Alternate Level of Care (ALC) Policies in Ontario

Andrea Pace[1], Diya Ahmad[1], Laura Jamieson[2], Kristina Kokorelias[3], Guillaume Lim Fat[3].
[1]University of Toronto, Temerty Faculty of Medicine; [2]University of Limerick, School of Medicine; [3]Department of Geriatrics, Mount Sinai Hospital, Toronto.

Background/Purpose: Alternate Level of Care (ALC) patients occupy hospital beds while no longer requiring the intensity of services provided in that setting, impacting patient flow and contributing to overcrowding. Ongoing updates to provincial legislation and hospital policies have aimed to target this ubiquitous issue, though center-specific protocols are heterogenous. This study aims to conduct an environmental scan of ALC policies from Ontario hospitals to assess variations in how ALC patients are identified, managed, and supported.

Method: The research employed a multi-phase approach, including a review of ALC policies obtained through direct inquiry and publicly available documents. Common practices and differences in key areas such as risk identification, clinical criteria, leadership roles, early discharge planning, and patient engagement were identified through content analysis of the acquired policy documents.

Results: Content analysis of nine policy documents revealed consistency in the core definition of ALC patients but variability among substitute decision-maker roles, caregiver supports, and discharge planning protocols. Common practices stressed early identification, particularly for frail older adults with dementia. Variability existed in the application of senior-friendly care principles, with emphasis on discharge rather than successful transitions, suggesting opportunities for improvement in person-centered care.

Discussion: ALC policies vary greatly and exhibit both strengths and gaps in addressing patient flow and care coordination. Comprehensive discharge planning models which maintain a person-centered approach could help mitigate patient flow challenges without loss of senior-friendly care principles by strengthening caregiver engagement and improving coordination across healthcare settings. These findings could promote a more cohesive ALC management strategy.

Dancing to Reduce Frailty: A Pilot Randomized Controlled Trial of Virtual GERAS DANCE

Aastha Relan[1], Patricia Hewston[1], George Ioannidis[1], Courtney Kennedy[1], Caroline Marr[1], Genevieve Hladysh[2], Alexandra Papaioannou[3].
[1]McMaster University, GERAS Centre for Aging Research, Hamilton Health Sciences; [2]YMCA Hamilton Burlington Brantford; [3]McMaster University, GERAS Centre for Aging Research, Hamilton Health Sciences.

Background/Purpose: Frailty is a condition of reduced function and health in older adults. Effective and accessible interventions targeting frailty can improve independence and quality of life. This study aimed to explore the effect of virtual GERAS DANCE on multidimensional frailty in older adults by assessing change in frailty index total and sub-domain scores.

Method: A single-center, prospective, parallel-group RCT assessed the feasibility of a 6-week virtual GERAS DANCE program compared to usual activities. We randomized 46 community-dwelling older adults (aged 60+) to an intervention group (twice-weekly 1-hour virtual dance sessions) or control group with usual activities. Frailty was measured using a frailty index with items considering medical history, physical performance, cognitive, nutrition, daily function, and psychosocial domains. Independent t-tests compared pre-post frailty scores between groups. The threshold for clinically meaningful change was 0.03 (Theou et al., 2020) with $p<0.007$ (Bonferroni correction) statistically significant.

Results: Our sample was 92% female with mean age 75.0±5.9 years. In the virtual GERAS DANCE group, total frailty scores improved (-0.02±0.06) while in the control group, scores worsened (+0.02±0.05). This between-groups mean difference (0.04±0.02, $p=0.03$) was clinically meaningful. Sub-domain index analyses revealed the largest effect on daily activities (0.09±0.02, $p<0.001$) and physical performance (0.09±0.05, $p=0.06$), though the latter was not statistically significant.

Discussion: Virtual GERAS DANCE may effectively reduce frailty through clinically meaningful improvement in daily function and physical performance, highlighting its feasibility as a virtual intervention. Our results support the need for larger trials to validate these findings and further explore the program's impact on frailty and related outcomes.

Recruitment Strategies for Older Adults in Frailty Research

Alexandra Papaioannou[1], Patricia Hewston[1], Ashlee Azizudin[1], Courtney Kennedy[1], Justin Lee[1], Caitlin McArthur[2], Shyam Mahara[1], Jonathan Adachi[1], Pauline Boulos[1], Raja Bobba[1], Alexander Rabinovich[1], Brian McKenna[3], Palubiski Lisa[4], Dee Mangin[1], Lehana Thabane[1], Sharon Marr[5], Sharon Kaasalainen[1], Jean-Éric Tarride[1], Olga Theou[2], David Armstrong[1], Ahmed Negm[6], Michael Noseworthy[1], Kenneth Rockwood[2], Lisa Dolovich[7], Genevieve Hladysh[1], Karen Thompson[1], George Ioannidis[1].
[1]McMaster University; [2]Dalhousie University; [3]Hamilton Family Health Team; [4]Escarpment Health Centre; [5]Unity Healthy Toronto; [6]University of Alberta; [7]University of Toronto.

Background/Purpose: The ability to self-identify frailty is key for early intervention, tailored support, and effective self-management. Self-identification empowers individuals to take charge of their health and enables healthcare providers to offer timely, personalized care. This study explores recruitment strategies, specifically evaluating the effectiveness of a newspaper article in engaging older adults with frailty and encouraging participation in frailty-related research.

Method: A front-page local newspaper article invited adults aged ≥65 with energy or mobility loss to self-refer for a frailty rehabilitation study. The article featured a personal success story and highlighted the benefits of addressing frailty. Interested older adults were pre-screened for mobility-disability, defined as difficulty walking a block or climbing stairs. Eligible participants were further screened using the FRAIL Scale (pre-frail=1–2, frail=3–5).

Results: Within 72-hours of the newspaper article release, 333 community-dwelling older adults expressed interest in the study. Of these, 220 (66%) met the pre-screening eligibility criteria. Of the 113 who were ineligible at pre-screening, the main reasons for ineligibility were no self-reported difficulty walking or climbing stairs (n=14), time constraints (n=11), transportation (n=8), lack of interest (n=6), illness (n=2), age <65 (n=1) and no response (n=71). An additional 139 people were waitlisted and did not complete baseline assessments using the FRAIL Scale. Of the 81 participants that completed baseline assessments (mean age 80 years [SD 6.2], range 66–93; 60% female), 52% were pre-frail and 48% were frail on the FRAIL Scale.

Discussion: Narrative-driven recruitment effectively engaged the target population, showcasing the utility of self-referral campaigns for early frailty detection and intervention.

Arriving Alone to an Outpatient Memory Clinic Nearly Rules Out Dementia Diagnosis

Allen Y Chang[1], Samuel D Searle[1].
[1]Dalhousie University Division of Geriatric Medicine.

Background/Purpose: Collateral information is a foundational component when performing a cognitive assessment and is required and requested for assessments at Dalhousie's Division of Geriatric Medicine outpatient clinic. However, when patients arrive alone, workflow process is disrupted and additional time is required to track down collateral information. We, therefore, investigate the prevalence of dementia in patients who present alone to clinic.

Method: A retrospective chart review of all outpatient clinic patients from January 2023 to December 31, 2023 was performed. From the chart review, the following relevant information was obtained – whether the patient arrived alone, their final cognitive diagnosis, and their MMSE and miniCog scores. Likelihood (LR) ratios and predictive values (PV) were analyzed.

Results: A total of 1320 outpatient encounters were reviewed and met the inclusion criteria, of which 135 arrived alone. Based on the cognitive diagnoses, those who arrive alone are 94.1% likely to not have dementia, or a 0.07 +LR. When MMSE scores are considered, the +LR is 0.02, and 0.04 when considering the miniCog.

Discussion: While collateral information remains an important part of the comprehensive geriatric assessment, we determine that patients arriving alone in the outpatient setting are highly unlikely to have dementia. Furthermore, individuals who arrive alone and have a normal range MMSE and miniCog are even less likely to be diagnosed with dementia.

The Potentially Inappropriate Use of Psychotropic Medications in Home Care Residents

Jocelyn Chan[1], Caitlin McArthur[2], Sid Feldman[3], Alexandra Papaioannou[4], Justin Lee[5].
[1]Michael G. DeGroote School of Medicine, McMaster University, Hamilton, Canada; [2]School of Physiotherapy, Dalhousie University, Halifax, Canada; [3]Department of Family and Community Medicine, University of Toronto, Toronto, Canada, Baycrest Health Sciences, Toronto, Canada; [4]GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada, Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Canada; [5]Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Canada, Centre for Integrated Care, St. Joseph's Health System, Hamilton, Canada, GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada.

Background/Purpose: Demand for home care services are high due to a growing preference of individuals with medically complex conditions to age in their own home rather than in long-term care. Home care recipients can experience neuropsychiatric and mental health issues for which psychotropic medications are prescribed. These medications can have significant negative consequences if not used appropriately and monitored, and can result in falls, hospitalization, or death.

Deprescribing initiatives have largely focused on long-term care population, but evaluation and development of strategies for home care recipients is limited. We sought to determine the prevalence of psychotropic medication use amongst home care recipients and how these rates compare to long-term care residents and the general older adult population.

Method: We analyzed data from the Resident Assessment Instrument-HC (RAI-HC). We included home care recipients in Ontario, Canada enrolled between April 1st, 2011 and August 31, 2018, receiving services for ≥ 6 months (n=850,803).

Results: In the week prior to RAI-HC assessment, 48% of home care recipients had taken at least one psychotropic medication while 17.9% had taken two or more. The most common psychotropic medications taken were hypnotics (24.4%), followed by antidepressants (22.8%), anxiolytics (14.8%), and antipsychotics (9.6%). 21% of the population had dementia, 14.7% had a psychiatric disorder, and 18.9% had depression.

Discussion: The prevalence of potentially inappropriate psychotropic medication use in home care recipients is high. A deeper exploration of the appropriateness of these prescription patterns is needed to determine whether prescriber and health-system level interventions are necessary to optimize medication use.

Exploring the Impact of ECHO Care of the Elderly Program & Case Recommendations on Healthcare Providers' Practices & Patient Care

Shaen Gingrich[1], Amna Akhtar Malik[2], Meaghan S Adams[2], Lisa Guttman Sokoloff[3], Sid Feldman[2], Devin J Sodums[4], Akinkunle Oye-Somefun[5], Anna Theresa Santiago[6], James Chau[7], Cindy Grief[2], David Conn[2].
[1]North East Specialized Geriatric Centre; [2]Baycrest; [3]Sheridan College; [4]Valparaiso University; [5]Ontario Health; [6]UHN; [7]North East Specialized Geriatric Centre.

Background/Purpose: Baycrest and the North East Geriatric Specialized Centre partner to deliver Project ECHO: Care of the Elderly (COE), a virtual capacity-building education and mentorship program for healthcare providers caring for older adults across Ontario.

Method: Each ECHO COE session centered on the discussion of a de-identified patient case drawn from participants' clinical practice. Each session also included a didactic presentation. Program evaluation measured provider's ability to implement recommendation and best practices learned in ECHO COE in their own practice, as well as their comfort level and self-efficacy working with older adults. Quantitative and qualitative methods were used to analyze the survey data collected over a 6-year period from a total of 605 interprofessional participants from across the field of geriatrics.

Results: Participants who presented a case during ECHO COE were able to implement both pharmacological and non-pharmacological recommendations, and the majority also applied these recommendations more widely in their practice than with the patient whose case they presented. ECHO COE also led to a statistically significant increase in participants' self-efficacy and comfort level working with older adults and those with dementia.

Discussion: The majority of participants implemented information learned in ECHO COE into their clinical practice, aligning the patient care they provided with evidence and best practices. ECHO (COE) is an effective educational program with demonstrated ability to build provider capacity and optimize patient care.

Integration of a Local Support Model at Long Term Care Homes to Improve Care in Ontario

Victoria Zefkic[1], Mercedes Magaz[2], Heiwette Girma[1], Sandra Grgas[1], Shelly Li[1], Leahora Rotteau[2], Naushin Vasta[1], Brian M Wong[3], Andrea Moser[1].
[1]Women's College Hospital; [2]Centre for Quality Improvement and Patient Safety, Temerty Faculty of Medicine, University of Toronto; [3]Centre for Quality Improvement and Patient Safety, Temerty Faculty of Medicine, University of Toronto, Division of General Internal Medicine, Department of Medicine, Sunnybrook Health Sciences Centre, Toronto, Canada.

Background/Purpose: In October 2020, Ontario Health (OH) began connecting and coordinating Ontario's health care system using a 'hub and spoke' model. This model partnered hospitals with long term care (LTC) homes to address unmet needs for LTC residents. It was built on the foundations of the LTC + program developed and implemented in April 2020 to address COVID-19 concerns and promote the formation of an integrated care network.

Method: In April 2023, OH established the Toronto LTC Local Support Model that aimed to improve equitable access to external services (i.e., Nurse Navigation, virtual General Internal Medicine consultation and access to assessments by the Nurse Lead Outreach Team (NLOT)) for all LTC residents in the Toronto Region. This study describes the implementation of the Toronto LTC Local Support Model, and the evaluation framework developed to assess its impact at LTC homes.

Results: Primary outcomes included the creation of integrated care networks across the LTC Local support model for the OH Toronto Region and the expansion of clinical pathways available to LTC homes. Secondary outcomes involved describing program delivery, enumerating clinical encounters and concerns addressed, and outlining early impacts on emergency department transfer avoidance.

Discussion: The implementation of the Toronto LTC Local Support Model has led to improvements in access to and integration of external services across 75 LTC homes. This

integrated care network has enhanced service delivery, expanded clinical pathways, and increased care provision and coordination, fostering stronger relationships between acute care teams and LTC providers enabling LTC residents receive the care needed in the place needed

Impact and Perceived Value of iGeriCare e-Learning Among Dementia Care Partners and Others: Evaluation Using the IAM4all Questionnaire

Anthony Levinson[1], Stephanie Ayers[1], Sandra Clark[1], Roland Grad[2], Alexandra Papaioannou[1], Richard Sztramko[1].
[1]McMaster University; [2]McGill University.

Background/Purpose: Care partners of people living with dementia may benefit from web-based education. We developed iGeriCare, an award-winning internet-based platform with 12 multimedia e-learning lessons about dementia. This study evaluates user perceptions of the platform's impact and value.

Method: Between March 17, 2021, to January 9, 2025, data were collected after each lesson using the validated Information Assessment Method for all (IAM4all), which assesses outcomes of web-based consumer health information.

Results: A total of 1,077 responses were received, with a 93% completion rate and an average time spent of 3 minutes and 10 seconds. Of respondents, 38% identified as care partners, 29% were concerned about their own cognitive health or had a diagnosis of dementia, and 24% were health care providers or trainees. A majority (94%) found the lessons relevant (66% very relevant), and 99% understood the content well or very well. Respondents reported learning something new (61%), feeling motivated to learn more (58%), feeling validated (50%), were reassured (46%), or said the content refreshed their memory (37%). 98% reported their intention to use a lesson, including: to better understand something (73%), discuss the information with someone else (53%), or do things differently (38%).

Discussion: iGeriCare was perceived as highly relevant and understandable, with a strong intention to apply the learned content. A recently completed RCT, assessing its impact on caregiver knowledge, self-efficacy, and burden, is currently under analysis to further explore its efficacy.

Urinary Incontinence Discussions on Instagram: A Hashtag Analysis of Top Posts and Reels

Ayanna Virani[1], Saima Rajabali[1], Adrian Wagg[1].
[1]University of Alberta.

Background/Purpose: Health-related content is common on social media platforms, which offer a vast user base and interactive features. With over 1.4 billion users, Instagram is one of the most widely used platforms with user-generated content. Urinary incontinence (UI) is a prevalent problem in older adults. With increasing social media use amongst older adults, this study aimed to investigate how UI is represented and discussed on Instagram.

Method: A list of eighteen hashtags was developed with expert consultation and Instagram's related-search functionalities. The 28 instagram-generated top posts and reels under each hashtag were analyzed. Content type and authorship background were recorded. Quantitative data was also gathered for each post, including likes, comments, and followers.

Results: Categories of content included education (46%, n=207), advertisements (41%, n=182), humour (6%, n=27), personal stories (3%, n=13), research/academia (3%, n=14), and unrelated to UI (1%, n=6). Healthcare professionals contributed 56% of the educational content (116 of 207 posts). The "unrelated to UI" category surpassed the remaining categories with the most engagement at 335 median likes, followed by personal stories (74 median likes) and humorous content (59 median likes).

Discussion: Education and advertisements had the most content, revealing Instagram's role in informing and promoting. Engagement data suggested discomfort with UI, an interest in "personal stories", and the effectiveness of humourous content in capturing attention. Instagram is a pertinent tool for disseminating information on UI. More healthcare professionals need to engage with this platform to improve the credibility and relevance of content while focusing on engaging content categories to improve outreach.

Primary Health Service Use Among Persons Living with Dementia: Exploring Inequalities Across Social Determinants of Health

Xia Wang[1], Yaning Gao[1], Isabelle Vedel[1], María Alejandra Rodríguez[1], Claire Godard-Sebillotte[1].
[1]McGill University.

Background/Purpose: Primary care is vital in dementia care management and diagnosis, yet people living with dementia (PLWD) face many challenges in accessing care. Social determinants of health factors such as material deprivation and being part of a visible minority group may contribute in differences in access. The study aims to describe primary care use in community-dwelling older adults with dementia in Quebec using health administrative databases; to explore potential inequalities across social determinants of health by comparing primary care use of persons with dementia by material deprivation and visible minority status.

Method: A retrospective study using health administrative data accessed at the Institut de la Statistique du Québec (ISQ). These databases record most services provided via the public health insurance system, including primary care visits. The descriptive analysis was conducted to examine material deprivation (MDI), racialization (RI) on primary care utilization among PLWD in Quebec. Health administrative data were linked with census-based neighborhood data to analyze these associations.

Results: Findings indicate that individuals in less deprived, more racialized neighborhoods had higher primary care visit rates. The fewest PLWD were found in the least deprived and most racialized neighborhoods, where the mean number of visits was highest. In contrast, those in highly deprived neighborhoods with more PLWD had fewer visits on average.

Discussion: The findings suggest potential barriers to accessing primary care in more deprived areas, including limited healthcare resources and socioeconomic challenges. These results underscore the complex relationship between material deprivation and racialization in determining healthcare access.

Assessing Feedback Quality in Geriatric Medicine: Analyzing Entrustable Professional Activities in a Competency-Based Curriculum

Azin Dolatabadi[1], Aathmika Nandan[1], Dov Gandell[2].
[1]Temerty Faculty of Medicine, University of Toronto; [2]Sunnybrook Health Sciences Centre, Department of Geriatric Medicine.

Background/Purpose: Competency-Based Medical Education (CBME) emphasizes providing timely, actionable feedback through Entrustable Professional Activities (EPAs) to improve medical training quality. However, variability in feedback quality remains a challenge across residency programs.

Method: We conducted a retrospective analysis of EPA feedback forms from a geriatric medicine program, comparing two time periods: 2019–2020 and 2021–2022. Feedback quality was evaluated based on timeliness, task orientation, actionability, and polarity.

Results: In 2019-2020, 404 EPAs were initiated and completed, with 69% (n=278) being timely, 89% (n=360) task oriented, 50% (n=203) very actionable, and 62% (n=250) corrective in polarity. In 2021-2022, 645 of 851 (n=76%) EPAs were completed, with 64% (n=410) being timely, 78% (n=501) task oriented, 40% (n=259) very actionable, and 47% (n=305) corrective in polarity. Timely feedback in the second period was more likely to be task-oriented ($\chi^2(1)=11.87$, $P<.001$), actionable ($\chi^2(2)=24.40$, $P<.001$), and corrective ($\chi^2(3)=22.80$, $P<.001$). Compared to the second timeframe, EPAs completed in the first timeframe were more likely to be task oriented ($\chi^2(1)=22.08$, $P<.001$), actionable ($\chi^2(2)=25.54$, $P<.001$), and corrective in polarity ($\chi^2(3)=25.89$, $P<.001$).

Discussion: Feedback quality decreased over time following CBME implementation in a geriatric medicine program. While the root causes remain unexplored, they are likely multifactorial. Identifying and addressing these factors is critical to sustaining the quality of CBME feedback and achieving its intended educational outcomes.

Fluctuating Cognitive and Physical Signs as a Prominent Feature in Probable Creutzfeldt-Jakob disease: A Case Report

Allen Y Chang[1], Jasmine Mah[1], Jenna MacDonald[2], Saffire Krance[1], Ayman Moustaine[1], Sultan Darvesh[1], Katalin Koller[1], Laurie Mallery[1], Paige Moorhouse[1], Kenneth Rockwood[1].
[1]Dalhousie University Division of Geriatric Medicine; [2]Jasmine.Mah@nshealth.ca.

Background/Purpose: A definitive diagnosis of Creutzfeldt-Jakob Disease (CJD) requires neuropathologic examination. Probable CJD can be diagnosed using clinical, radiographic, and electroencephalographic features, plus CSF analysis with quaking-induced conversion (RT-QulC) test. We report an atypical presentation that nearly led to a misdiagnosis despite using established diagnostic criteria.

Method: A 74-year-old female presented with a 4-month history of progressive impairment of short-term memory, gait and balance difficulties, paranoia, and impulsivity. Routine blood work and MRI, performed 2 months after symptom onset, were unremarkable. The patient was hospitalized 4 months post symptom-onset for further investigation. Collateral history revealed mood fluctuations, apathy, dream enactment, and visual hallucinations. Physical exam findings fluctuated, showing an intermittent broad-based gait with shortened stride, rigidity, and frontal release signs. Speech was dysarthric. Cognitive testing demonstrated deficits in recall, executive function and visuospatial function.

Results: An EEG showed non-specific slowing. CSF analysis found no infectious or inflammatory processes and RT-QulC test result is pending. Repeat MRI demonstrated FLAIR hyperintensity and increased DWI signal in the caudate and lentiform nuclei, bilaterally—findings strongly suggestive of CJD. While in hospital, the patient experienced rapid decline in mobility and worsening paranoia and agitation.

Discussion: Rapid cognitive decline, paranoia, hallucinations, and fluctuation initially led physicians to consider a diagnosis of Dementia with Lewy Bodies or a psychiatric disorder. While some of these features have been described in CJD, pronounced fluctuations in physical examination and behavior have not. Clinicians investigating and managing possible CJD and rapidly progressive dementias need greater awareness of these features.

Fostering Emotional Communication in Dementia Care Through Positive Audiovisual Content

Barbara Delacourt[1], Raed El-Aoun[1], Omar Graja[2], Ahmed Rebei[2], Santiago Hidalgo[3], Ana Inés Ansaldo[4].
[1]IUGM Research Center; [2]IUGM Research Center; [3]Faculty of Arts and Science, University of Montreal; [4]IUGM Research Center.

Background/Purpose: People living with dementia (PWD) face communication challenges as early as the initial stages

of the disease, which progressively worsen over time. In advanced stages, persistent communication breakdowns reduce exchanges with caregivers, often resulting in the isolation of both communication partners. Previous studies have shown that co-viewing audiovisual content with positive emotional valence fosters emotional communication between PWD and caregivers, reduces caregiver burden, and enhances empathy.

Method: Eight PWD and eight caregivers (four family members and four professionals) were recruited in a long-term care setting. Caregivers co-viewed audiovisual clips with positive emotional valence for 20 minutes, 2–3 times per week, over a period of 3 weeks. Heart rate and electrodermal activity were measured using wearable devices, while facial expressions were analyzed with cameras. Pearson correlations were applied to identify moments of synchronization between participants.

Results: The results reveal statistically significant synchronization in heart rate and electrodermal activity between PWD and their caregivers during co-viewing sessions. Facial expressions, predominantly associated with joy, were also synchronized throughout the activity, indicating shared emotional experiences

Discussion: These findings highlight the potential of co-viewing as a strategy to promote emotional communication within caregiver–PWD dyads. Synchronization between individuals emerges as a fundamental mechanism of communication, fostering empathy and reinforcing emotional connection.

Supporting Sexual Health for People Living with Dementia in Long-Term Care: Building Confidence Through E-Learning

Birgit Pianosi[2], Emalyn Thielking, Katelynn Aelick[1], Lori Schindel Martin[3], Rosemarie Mangiardi[4], Kristy McKibbon[5].
[1]North Bay Regional Health Centre; [2]Laurentian University; [3]Toronto Metropolitan University; [4]Ontario Health, [5]Hamilton Health Sciences.

Background/Purpose: Behavioural Supports Ontario (BSO) supports individuals with dementia and complex mental health conditions experiencing responsive behaviours. While BSO teams excel in assessing behaviours and creating care plans, challenges remain in addressing responsive sexual behaviours. To bridge this gap, the BSO Sexual Expression and Dementia (SED) Working Group created an eLearning series on sexuality, dementia, and responsive behaviours.

Method: The BSO SED Working Group conducted an extensive review of over 300 articles and grey literature from various countries, complemented by consultations with healthcare providers (HCPs) and experts. This evidence-informed approach guided the creation of an engaging eLearning series designed to address knowledge gaps and align with best practices in dementia and sexual health.

Results: The first module in the series focuses on shaping learners' values, knowledge, and beliefs surrounding sexual health and dementia. The second module equips HCPs with practical skills and tools to engage in productive, respectful conversations about sexual health with long-term care (LTC) residents. In the third module, learners assess the risks associated with sexual behaviours and develop strategies to address those that pose risk, ensuring a balance between safety and dignity.

Discussion: Supporting the Sexual Health of People with Dementia in LTC provides freely accessible education to HCPs on a topic that is important to their resident's well-being but is rarely included in other education and training. Learners become equipped with practical tools to guide their interactions with residents, their care partners, and care team on supporting the sexual health of people with dementia.

Moving Beyond Prevalence and Incidence Studies: A Novel 3-Month Pressure Injury Analysis for Assessing Pressure Injuries in a Geriatric Hospital Demonstrated a 41% Decrease in Foot Pressure Injuries in 1 year

Ceilidh Matthews[1], Nilushi De Silva[1], Gina Pohani[2], Evan Chong[2], Carol Ott[1].
[1]University of Toronto; [2]Baycrest Health Sciences.

Background/Purpose: Pressure injuries (PIs) are a significant challenge in geriatric hospital settings. Traditional prevalence and incidence studies offer limited insights, providing PI data at only a snapshot in time. To address this, a novel 3-month Pressure Injury Analysis was implemented at a 272-bed geriatric hospital in Toronto that includes complex continuing care, rehabilitation, psychiatry, and transitional care units.

Method: A 3-month chart review was conducted in 2023, analyzing PI stage, location, acquisition context – internal (IA) vs. external (EA), and ward-specific trends. Patients who did not consent, had PIs for more than two years, or who passed away during the study period were excluded. Findings informed targeted interventions and led to a repeat of the study in 2024.

Results: In 2023, 73% (11/15) of internally acquired pressure injuries were located on the feet. Targeted interventions were implemented: 1. Heel Offloading Pillows: Introduced hospital-wide; 2. Ward Wound Rounds: Focused on units with the highest PI incidence; 3. Increased Clinical Awareness: Education on foot care and bed positioning. By 2024, although the total number of IAPIs rose to 19, only 32% (6/19) were on the feet.

Discussion: The 2023 analysis led to tailored interventions, leading to measurable improvements in PI management and outcomes. Implementing a novel 3-month study allowed for analysis of trends that could be targeted as a quality improvement project. The 3-pronged implementation resulted in a

41% reduction in internally acquired foot PIs, ultimately demonstrating the effectiveness of targeted interventions in reducing PIs.

Barriers and Facilitators to Pharmacist-Led Deprescribing of Antihypertensive in Long-term Care: A Cross-sectional Study

Cheryl Sadowski[1], Ana Vucenovic[1], Donna Manca[1], Roni Kraut[1].
[1]*University of Alberta.*

Background/Purpose: OptimizeBP is a randomized controlled antihypertensive deprescribing trial in Alberta, Canada, with pharmacists primarily conducting the deprescribing. The objective was to describe the facilitators and barriers that pharmacists experience while deprescribing antihypertensive medication in long-term care facilities.

Method: This cross-sectional study enrolled pharmacists participating in the Optimize BP study who were asked to complete surveys pre- and post-intervention. The surveys, informed by the RE-AIM knowledge translation, were designed through an iterative process with pharmacist input and consist of open- and closed-ended questions.

Results: Nine pharmacists completed both the pre- and post-intervention survey (7 female; 5 have been a pharmacist ≥10 years; and 8 had their Additional Prescribing Authority [provides authority to prescribe to full scope of practice]. The key facilitators were (1) pharmacist confidence and attitude toward deprescribing, median confidence pre: 8/10 (interquartile range [IQR] 6–8), post: 9/10 (IQR 8–9.3); (2) sufficient data, which increased post-intervention with all pharmacists feeling that adequate data was available; and (3) minimal tools and education required besides one-hour orientation and algorithm. The key barriers included (1) pharmacist perception they are not the primary decision maker on prescribing decisions; (2) insufficient support from residents' families and physicians; more pharmacists listed this as a top barrier post-intervention; and (3) additional time required to deprescribe antihypertensives; this barrier was noted by more pharmacists post-intervention.

Discussion: Both facilitators and barriers for pharmacists to deprescribe antihypertensive deprescribing were identified. Without system level interventions, the barriers will make it challenging for pharmacists to incorporate deprescribing antihypertensives into routine care.

Dementia Risk Reduction Internet-Based Learning for Canadians: Effects on Knowledge, Intentions, and Health Behaviours

Anthony Levinson[1], Stephanie Ayers[1], Sandra Clark[1], Rebekah Woodburn[1], Maureen Dobbins[1], Dante Duarte[1], Roland Grad[2], Dima Hadid[1], Nick Kates[1], Sharon Marr[1], Doug Oliver[1], Alexandra Papaioannou[1], Karen Saperson[1], Amy Schneeberg[3], Henry Siu[1], Gillian Strudwick[4], Richard Sztramko[1], Sarah Neil-Sztramko[1].
[1]*McMaster University;* [2]*McGill University;* [3]*University of British Columbia;* [4]*Centre for Addictions and Mental Health.*

Background/Purpose: Dementia risk can be reduced by as much as 45% through modifiable lifestyle factors. However, public knowledge of dementia risk and protective factors remains low. Web-based education offers a potential solution to raise awareness and promote risk reduction behaviours. DementiaRisk.ca, an award-winning, free web-based resource available on the McMaster Optimal Aging Portal features a 35-minute multimedia e-learning lesson about how to promote brain health, resources about modifiable dementia risk factors, email-based 'micro-learning,' and an interactive quiz.

Method: A two-arm RCT was conducted with 510 participants (265 in the intervention group and 245 in the control group). Participants were randomized to receive e-learning about dementia risk and promoting brain health, or a control intervention focused on mild cognitive impairment (MCI). Outcomes included knowledge of dementia risk factors, intentions to engage in risk reduction, and health behaviours, measured at baseline, 4 weeks, and 3 months.

Results: The intervention group showed significant improvements in knowledge, intentions, and health behaviours compared to the control group. Participants with lower educational attainment exhibited the largest knowledge gains. Health behaviours, particularly physical activity, increased significantly among the intervention group. Qualitative findings revealed widespread and profound interest among participants in gaining a comprehensive understanding of dementia – its symptoms, risk factors, and preventive strategies.

Discussion: DementiaRisk.ca effectively increased knowledge and promoted risk-reduction behaviours. Healthcare and public health professionals, and others that work with adults and older adults, should promote this resource during patient/client interactions. Integrating such programs into health policies could enhance dementia prevention efforts and public awareness across diverse communities.

The Standard of Care for Older Adults Living With/At-risk of Frailty: A Framework for Equity and Excellence

Dana Corsi[1], Nicole Gallagher[1], Jo-Anne Clarke[1], Shaen Gingrich[1], Melanie Briscoe[1].
[1]*North East Specialized Geriatric Centre, Health Sciences North.*

Background/Purpose: Older adults living with/at-risk of frailty require a consistent, evidence-based approach to care that addresses their complex needs across the continuum. In Ontario, numerous provincial clinical guidelines have been developed to meet these needs. However, variability in implementation has constrained their overall impact. The purpose

of our work was to synthesize these guidelines into a unified framework, to enable equity-driven improvements in care delivery and outcomes for this population.

Method: The Standard of Care for Older Adults Living With/At-Risk of Frailty was developed through a structured inductive process. We reviewed 22 provincial clinical guidelines to identify best practices across diverse objectives. Recurring themes were identified through pattern recognition, focusing on shared elements, processes and domains. These findings were synthesized into a cohesive framework designed to standardize care delivery while allowing flexibility for context-specific adaptation. Stakeholder engagement and feedback validated the framework's relevance and benefit for implementation.

Results: The Standard of Care for Older Adults Living with/At-risk of Frailty includes: Core Elements of Care, Processes of Care, and Domains of Care. It fosters consistency in care delivery by standardizing the core components of care that are required to reduce variability and promote equitable access.

Discussion: The Standard of Care provides a replicable, equity-driven framework for advancing care for older adults living with/at-risk of frailty. It provides the structure for aligning diverse guidelines into a unified model, strengthening population-based infrastructure to address system priorities. This adaptability ensures effective localized implementation while fostering equity and quality across systems.

Managing Agitation in Emergency Medical Services for Older Adults: A Qualitative Exploration in Alberta, Canada

Fatima I Shah[1], Grace Lew[1], Ryan Lee[2], Krista Reich[1], Kathryn Crowder[1], Ian Blanchard[2], Zahra Goodarzi[1].
[1]University of Calgary; [2]Alberta Health Services.

Background/Purpose: Emergency medical services (EMS) paramedics are often the first point of contact for agitated older adults (OAs), providing critical lifesaving support and transport to the emergency department. However, there is limited knowledge around agitation management and restraint use in OAs by EMS. We aim to explore the scope of paramedics' experiences with management of agitation and restraint use in OA.

Method: Paramedics (n=30) employed in Alberta participated in semi-structured interviews regarding their perspectives on agitation, physical/chemical restraint use for OAs in EMS, and non-restraint alternatives for agitation management. We analyzed the data using thematic analysis and deductive coding to the theoretical domains framework that links to the behaviour change wheel to identify key barriers to agitation management.

Results: Paramedics reported inadequate training and support, especially for managing agitation in OAs. The decision to use restraints is often collaborative between professionals on scene, and requires careful balance of risks, benefits, and ethical considerations. Restraints are considered a necessary safety measure but are often used as a last resort after all other agitation management strategies have failed. Communication and de-escalation strategies were commonly used, however, paramedics identified several environmental and systemic barriers (unpredictable environments, limited resources, lack of de-escalation training), as well as patient specific challenges (communication difficulties, altered mental status, comorbidities), leading to greater restraint use and burnout.

Discussion: These findings highlight challenges faced by paramedics in the EMS system in managing agitation in OAs, emphasizing the need for improved education and training, systemic support, and resources to reduce restraint use.

360 Living Models: A Blueprint for Age-Friendly Communities

Lisa Beaudoin[1], Dana McAuley[1], Erin Meikle[2], Zannat Reza[1], Lindsay Cox[1], Tazim Virani[1], Jennifer Olson[2].
[1]SE Health; [2]Covenant Health.

Background/Purpose: Almost all older adults want to live at home as they age, however supports to help them thrive are fragmented. At the COURAGE: Action for Better Aging Summit the concept of 360 Living Models was supported by cross-sectoral champions. These models take a holistic approach to support the well-being of older adults, where housing, health and social supports are integrated. Although there are existing models, there is no common set of elements to ensure integration. The objective was to create a 360 Living Model Blueprint to serve as a guide on essential elements that can be adapted to the diverse and changing needs of communities.

Method: A collaborative approach was used that included a systematic environmental scan, literature review, analysis of existing models, expert input and review of the draft blueprint to validate against current applied promising approaches, and consultation with older adults and the COURAGE coalition to gain consensus.

Results: The blueprint establishes common language, including a broad definition, supporting pillars and the essential elements required for 360 Living Models that communities can use when co-designing the built and non-built environments in their local regions.

Discussion: This initiative demonstrates a broad desire for integrated supports to help older adults remain in the community. The blueprint is one step in reimagining aging in Canada. The scan of models can be used to inspire similar initiatives in communities.

Crises in Care: A Scoping Review of Emergency Department Utilization by Residents of Assisted Living Facilities

Drew Langille[1], Pamela Jarrett[1], Paul Atkinson[1].
[1]*Dalhousie University.*

Background/Purpose: Residents of assisted living facilities frequently visit emergency departments due to preventable conditions like falls, infections, and exacerbations of chronic illnesses. This scoping review explores the reasons for emergency department visits by residents of assisted living facilities and evaluates interventions to reduce reliance on emergency care.

Method: We conducted a scoping review using Arksey and O'Malley's framework, supplemented by PRISMA-ScR guidelines. A search of PubMed, Medline, EMBASE, and SCOPUS databases was conducted for English-language studies published between 2014 and 2024. Included studies examined emergency department utilization by assisted living facility residents, focusing on causes, outcomes, and interventions. Data were extracted on study characteristics, reasons for emergency department visits, and intervention efficacy.

Results: A total of 18 studies met the inclusion criteria. Frequent emergency department visits were attributed to falls, infections, exacerbations of chronic conditions, and medication-related issues. Effective interventions included telemedicine consultations and paramedic decision-making protocols, which reduced unnecessary transfers. Gaps in the literature were identified regarding long-term sustainability and the role of resident and family education.

Discussion: This review highlights preventable causes of emergency department visits among assisted living facility residents and suggests scalable interventions, such as telemedicine, enhanced staff training, and resident education. Stakeholders must prioritize these strategies to improve care quality and reduce emergency department congestion. Future research should focus on the cost-effectiveness and sustainability of these approaches.

A Frailty Index in CAN-PROTECT: Associations with Cognition and Behavior in Community-dwelling Older Adults Living Without Dementia

Dylan Guan[1], Zahra Goodarzi[2], Kenneth Rockwood[3], Clive Ballard[4], Byron Creese[5], Anne Corbett[4], Ellie Pickering[4], Pamela Roach[6], Eric Smith[7], Zahinoor Ismail[7].
[1]*Hotchkiss Brain Institute, University of Calgary;* [2]*Cumming School of Medicine, University of Calgary, Calgary, Canada;* [3]*Division of Geriatric Medicine, Department of Medicine, Dalhousie University, Halifax, Canada;* [4]*Clinical and Biomedical Sciences, Faculty of Health and Life Sciences, University of Exeter, Exeter, UK;* [5]*Department of Psychiatry, College of Health Medicine and Life Sciences, Brunel University London, London, UK;* [6]*Department of Community Health Sciences, University of Calgary, Calgary, Canada;* [7]*Hotchkiss Brain Institute, University of Calgary, Calgary, Canada.*

Background/Purpose: Frailty captures physiological vulnerability to adverse health outcomes and can be measured using a cumulative health deficit approach, known as the frailty index (FI). While higher FI is linked to dementia, its relationship with cognitive and behavioural changes preceding dementia remains unclear.

Method: Baseline data from 1556 functionally independent older persons in CAN-PROTECT, a nation-wide online longitudinal cohort study of brain aging. were analyzed. Follow-up and study partner data were available in 516 and 661 participants, respectively. A CAN-PROTECT-specific FI was calculated based on 59 health deficits. Cognition was assessed using neuropsychological tests and self-/study partner-reported Everyday Cognition Scale (ECog-II). Behaviour was measured using the self-/study partner-reported Mild Behavioral Impairment Checklist (MBI-C). Linear/generalized mixed-effect models examined associations between FI (exposure) and cognition and behavior (outcomes), adjusting for age, sex, education, and time.

Results: Participants (80.1% female; 64.7±7.6 years old) had completed 15.9±3.1 years of education with mean FI=0.13±0.08, mean ECog-II=12.1±11.6, and mean MBI-C score=5.4±7.2. In adjusted analyses, every 0.1 rise in FI was associated with a 0.03 (95%CI: [-0.06, -0.01], p=.02) lower neuropsychological composite z-score, 1.67 (95%CI: [1.58, 1.75], p<.001) times higher self-reported ECog-II score, and 2.49 (95%CI: [2.29, 2.70], p<.001) times higher self-reported MBI-C score. No statistically significant FI*time interactions were observed. Findings were consistent between self- and study partner-reported outcomes.

Discussion: Higher FI is associated with later-life changes in cognition and behaviour among functionally independent older adults. Frailty assessment among older adults may facilitate early detection and management of later-life cognitive and behavioral changes.

Should We Stop Doing Geriatric Assessments in Patients Under 75 with Cancer?

Elnaz Ziad[1], Michael Carter[1], Robert Grant[2], Shabbir Alibhai[3], Eldan Cohen[1]. [1]Department of Mechanical & Industrial Engineering, University of Toronto; [2]Princess Margaret Cancer Centre, University Health Network; [3]University Health Network.

Background/Purpose: The Older Adults with Cancer Clinic (OACC) performs geriatric assessments (GAs) for cancer patients aged 65+ and has both primary and secondary outcomes. With limited resources and increasing wait times, targeting age 75+ vs 65+ is being considered. Our objective is to compare whether the GA has a similar impact on the

treatment plan (primary outcome) and addressing abnormal GA domains and enhancements to care (secondary outcomes) for patients under 75 versus 75+.

Method: Data was obtained from a customized clinical database. Descriptive analytics were used to identify differences in the primary and secondary outcomes of GA for patients under 75 versus those 75+ using chi-square testing.

Results: For the primary outcome, the results reveal a significant association between age group and treatment changes (

Discussion: While patients aged 75+ are more likely to undergo treatment changes after GA, the 43.5% change rate among those under 75 suggests GA remains valuable for them as well. Furthermore, the absence of a difference between age groups in secondary outcomes confirms the value of GA in improving the care of patients under 75, as well as those aged 75+.

Exploring Homelessness, Health and Care Experiences with Older Calgarians: Identifying Opportunities to Improve Equity

Emma Mierau[1], Elaine Boyling[2], Sam Bagley[2], Kearah Darr[2], Martina Kelly[2], Lara Nixon[2].
[1]Cumming School of Medicine, University of Calgary; [2]Department of Family Medicine, Cumming School of Medicine, University of Calgary.

Background/Purpose: Older people with experiences of homelessness (OPEH) often have complex health, social, and housing needs that are unmet in existing service landscapes. The purpose of this study was to explore the housing and health experiences of OPEH, as well as their experiences of care.

Method: This study is part of an ongoing community-based participatory action program of research with OPEH partners in Calgary since 2019. People aged 50 or older with experiences of housing instability (n=23) were recruited from elder abuse shelter, independent low-income housing, and supportive housing settings, using snowball and purposive sampling. Quantitative and qualitative date were generated through 18 individual interviews and 7 focus groups conducted in community partner settings. Data analysis included descriptive statistics and thematic analysis.

Results: The mean of number of physical and mental health issues reported was 8.5 and 3, respectively. Most common health issues included: chronic pain, joint and mobility issues, diabetes, dental problems, anxiety and depression. One third reported moderate frailty (Self-reported Frailty Questionnaire, 3.2). Almost 30% experienced first homelessness over the age of 50 and all experienced at least two categories of homelessness (unsheltered, emergency sheltered, temporarily housed, and at-risk). Diverse barriers to care were reported: wait times, transportation, stigma, as well as stamina and financial constraints to self-care. Sense of neglect and being disrespected negatively impacted care-seeking for many.

Discussion: This study helps clarify OPEH's complex housing and health challenges and identifies myriad opportunities to mitigate harms arising from current care structures and resource deprivation.

Reducing Future Fracture Risk After High Trauma Fracture in Older Adults Part I - Examining the Care of Older Adults with High Trauma Fractures at a Level 1 Trauma Center in Canada

Farid Medleg[1], Camilla Wong[2], Victoria Elliot-Gibson[2], Amanda McFarlan[2], Eric Kai-Chung Wong[2], Sarah Ward[2].
[1]University of Toronto; [2]St. Michael's Hospital.

Background/Purpose: Describe the current landscape of fracture risk assessment in older adults with high-trauma mechanism fractures at a Level 1 Trauma Center in Canada.

Method: Retrospective chart review of adults 70 years and older presenting to hospital from January 1 to December 21, 2022 with a high-trauma mechanism fracture (hip, spine, pelvis, upper extremity, lower extremity) to determine proportions of bone health assessment identification, related investigations, and pharmacotherapy.

Results: 77 adults were analyzed. The need for bone health assessment was identified, fracture risk assessment completed, and recommendation made to primary care for a bone density scan in 40 (51.9%), 7 (9.1%), and 28 (36.4%), respectively. Only one had a bone density scan within six months of discharge. Calcium, phosphate, creatinine, and ALP was measured in 75 (97.4%), 75 (97.4%), 77 (100%), and 74 (96.1%) patients respectively; lower rates of TSH (55, 71.4%), SPEP (6, 7.8%), and vitamin D (39, 50.6%) were measured. Of 63 patients not taking vitamin D prior to admission, 35 (55.5%) were started in hospital. 62 patients received Geriatrics consultation which was associated with higher rates of identification for bone health assessment (65%) and laboratory measurements. In patients not receiving Geriatrics consultation, none received a fracture risk assessment.

Discussion: Most older adults with high trauma fractures do not receive fracture risk assessments and associated work-up during hospitalization. Geriatrics consultation was associated with higher rates of appropriate blood work and identification of the need for bone health assessment. Data was insufficient to characterize the likelihood of future fractures.

Navigating the Intersection of Aging and HIV: A Qualitative Exploration of Older Adults' Perspectives on Continuing Care in Southern Alberta

Farwa Naqvi[1], Jessica Dalere[1], M. John Gill[2], Raynell Lang[2], Jenine Leal[3], Caley Shukalek[2], Vivian Ewa[3], Katrina Milaney[4], Jeffrey Bakal[5], Nolan Hill[6], Paddy Quail[7], Mark Randall[8], Zack Marshall[9], Jacqueline McMillan[2].
[1]University of Calgary, Calgary, Alberta, Canada; Southern Alberta Clinic, Calgary, Alberta, Canada;

[2]University of Calgary, Calgary, Alberta, Canada, Southern Alberta Clinic, Calgary, Alberta, Canada, Alberta Health Services, Calgary, Alberta, Canada; [3]University of Calgary, Calgary, Alberta, Canada, Alberta Health Services, Calgary, Alberta, Canada; [4]University of Calgary, Calgary, Alberta, Canada; [5]University of Calgary, Calgary, Alberta, Canada, Provincial Research Data Services, Calgary, Alberta, Canada; [6]Centre for Sexuality, Calgary, Alberta, Canada; [7]Alberta Health Services, Calgary, Alberta, Canada; [8]Safelink Alberta, Calgary, Alberta, Canada; [9]University of Calgary, Calgary, Alberta, Canada, McGill University, Calgary, Alberta, Canada.

Background/Purpose: Advancements in antiretroviral therapies have extended the life expectancy of persons living with Human Immunodeficiency Virus (PLWH). As this population continues to age, many face unique challenges in maintaining independent living and may need additional support. This study explores the understanding, beliefs, and attitudes of older PLWH towards continuing care (from home care to long-term care) in Alberta.

Method: We conducted semi-structured interviews with PLWH aged ≥50 years at the Southern Alberta Clinic (SAC). Participants had previously completed a confidential online survey on their continuing care experiences. Thematic analysis was used to identify key themes.

Results: Twenty-five participants from diverse gendered, racialized, and other identity backgrounds residing in Southern Alberta were interviewed. Through thematic analysis, we identified several key themes; 1) Fear of HIV-stigma in care homes, among patients, within social circles, and at healthcare facilities; 2) Financial concerns related to continuing care; 3) Fear of loss of independence; 4) Challenges surrounding disclosure of HIV-status; and 5) Engaging with non-HIV specialist health care providers.

Discussion: These findings highlight the complex intersections of aging, HIV, and identity in shaping perceptions of continuing care. Addressing the unique needs of aging PLWH presents an opportunity to enhance geriatric care practices and improve the aging experience for the broader community. The demographic shift towards aging PLWH necessitates a focus on tailored educational resources and practical knowledge to navigate later life complexities, ensuring optimal well-being and satisfaction. Future interventions should focus on education, reducing HIV-stigma, and developing inclusive care models that respect diverse identities and experiences.

Comparing Older to Middle-Aged Drivers on a Driving Simulator

Frank Knoefel[1], Sylvain Gagnon[2], Fjolla Berbatovci[1], Meg Schwellnus[1], Andrew Frank[1], Neil Thomas[1], Shawn Marshall[1], Bruce Wallace[3], Rafik Goubran[3].
[1]Bruyere Health Research Institute; [2]University of Ottawa; [3]Carleton University.

Background/Purpose: Driving risk increases with aging and cognitive decline. Previous research has shown similarities between on-road driving tests and results on driving simulators. This work looks at differences in driving behaviours between middle-aged drivers (MD) and older drivers (OD) on a driving simulator.

Method: A driving battery using six driving modules from the Virage VM-500SR simulator was developed. Modules included isolated, single-task events, e.g. braking, and complex driving, e.g. a 15-minute simulated comprehensive driving test. Participants included 37 OD with an average age 73.8 years (61-91, F=18) and 33 MD with an average age 50.1 years (37-60, F=17).

Results: OD self-identified as driving less than MD (12,000km/yr vs 15,400km/yr, $p=0.07$). Only 18 OD (48.6%) and 17 MD (51.5%) were able to complete the full battery due to simulator sickness. OD had slower reaction times (dual taks: 0.77s vs 0.88s, $p<0.05$). OD drove slower (34.4km/h vs 36.9km/y, $p<0.01$). OD scored significantly lower on the Virage comprehensive driving test score (47.8 vs 65.1, $p<0.01$).

Discussion: This work is consistent with previous research. This OD group drove less distance per year. They had slower reaction times and drove slower on the simulator. They performed less well on the simulated comprehensive driving test. Unfortunately, there was significant drop-out due to simulator sickness. The findings provide preliminary evidence for using a Virage driving simulator to test driving in older adults. Future work will address the incidence of simulator sickness and look for driving differences between cognitively healthy and cognitively impaired OD.

The NESGC Implementation Playbook: A Framework for Enhancing Care and Equity for Older Adults Living With/At-risk of Frailty in Northeastern Ontario

Dana Corsi[1], Nicole Gallagher[1], Sara McEwen[1], Shaen Gingrich[1], Jo-Anne Clarke[1], Melanie Briscoe[1].
[1]North East Specialized Geriatric Centre, Health Sciences North.

Background/Purpose: Older adults living with/at-risk of frailty in Ontario's northeast face challenges, including geographic isolation, socio-economic disparities, and limited access to specialized care, leading to health inequities and system strain. To address these, North East Specialized Geriatric Centre (NESGC) developed the Implementation Playbook, a structured framework to operationalize the Standard of Care for this population, aiming to improve care quality, equity, and promote sustainable system change.

Method: Using a multi-phase strategy, we adapted and integrated evidence from population health, system science, quality improvement, knowledge translation, and implementation science models to develop The Playbook. To ensure

practicality and sustainability, implementation plans were co-designed within the local context.

Results: The Playbook's key components are: Identifying the opportunity, population profile, implementation roles, governance and accountability, current capacity, care pathway, and evaluation framework. These offer practical guidance for addressing challenges like Alternate Level of Care (ALC) and service inequities. The Playbook has facilitated implementation of over 30 Specialized Geriatric Services (SGS), training of 190 healthcare professionals, and improved access for more than 3,000 older adults living with/at-risk of frailty. The Playbook has been used to guide system-wide implementation work associated with reduced ALC designations, improved transitions, and increased access to high-quality geriatric care in rural, underserved areas.

Discussion: The NESGC Implementation Playbook is a replicable, evidence-based framework that addresses system-wide implementation of services that meet the needs of older adults living with/at-risk of frailty. Its success in northeastern Ontario offers a model for other regions, contributing to improved outcomes and equitable care nationwide.

Provision of Air Conditioning in Nursing Homes and Mortality During Extreme Heat: A Case-Crossover Study in Ontario, Canada

Michael P Hillmer[1], Gabrielle M Katz[2], Kevin A Brown[3], Sping Wang[1], Aidin Kerem[1], Qing Huang[1], Vasily Giannakeas[4], Kamil Malikov[1], Nathan M Stall[5].
[1]Ontario Ministry of Health, Toronto, Canada; [2]Temerty Faculty of Medicine, University of Toronto, Toronto, Canada; [3]Public Health Ontario, Toronto, Canada; [4]Dalla Lana School of Public Health, University of Toronto, Toronto, Canada; [5]Division of Geriatrics, Sinai Health, Toronto, Canada.

Background/Purpose: Extreme heat poses serious health risks to older adults, and many nursing homes lack air conditioning (AC). In July 2020, Ontario, Canada promised to mandate AC in nursing homes, and nearly all (99%) had AC by May 2023. We examined mortality during extreme heat days in nursing homes with AC compared to homes without AC.

Method: A time-stratified, case-crossover study of 615 nursing homes in Ontario, Canada from 2010-2023 during warm months (June–September). The study was self-controlled, with case days defined as when residents died of any cause and control days as 14 days prior. Extreme heat days were defined as ≥90th percentile of heat index (incorporates temperature and humidity) for each nursing home during the study period. We applied logistic regression models over multiple lag periods (lag 0, 0-1, 0-3, 0-6 days) to calculate the relative odds ratio (ROR) of mortality on extreme heat days in homes with AC compared to homes without AC.

Results: There were 40,255 deaths in homes with AC (mean [SD] age 86.8 [8.8], 65.6% women) and 33,323 deaths in homes without AC (mean [SD] age 87.2 [8.7], 64.8% women). AC was associated with significantly lower odds of mortality on extreme heat days (ROR=0.93, 95%CI=0.87-0.99). The association was significant across lag periods 0-1 days (ROR=0.93, 95%CI=0.87-0.99) and 0-3 days (ROR=0.92, 95%CI=0.87-0.99), but not 0-6 days (ROR=0.95, 95%CI=0.89-1.02).

Discussion: Mortality was lower during extreme heat days in nursing homes with AC. AC provision in nursing homes and other congregate settings may prevent mortality in older adults during extreme heat.

Improving Efficiency of a Virtual Interdisciplinary Geriatric Specialist Medication Optimization Service Through Operations Management: A Retrospective Study

Hai Ninh Vu, Joanne Ho, Jennifer Tung, Michael J. Pavlin, Danielle Yantha, Shazia Khokhar, Sophiya Benjamin.
Wilfrid Laurier University.

Background/Purpose: Timely access to care is essential in healthcare to improve patient outcomes and cost effectiveness. This retrospective quality-improvement study sought to improve operational efficiency of a virtual interdisciplinary geriatric consultation service in medication optimization.

Method: We examined clinical operational data from March 2022 to June 2024, including the impact of external factors (e.g., caregiver involvement, referral sources, care settings, geographical regions, and best possible medication history (BPMH) types, patient complexity) and internal factors (e.g., involvement of different clinician roles in interdisciplinary consultations, and full-time equivalents (FTE)). The primary outcome was completion time, calculated as the time from the referral day to the day the consult note was sent back to the referring clinician. Time-dependent regression analyses, performed at half-year intervals, controlled for unobserved operational changes over time and assessed the effects of a series of iterative operational adjustments to clinical workflow and digital infrastructure, and targeted changes in FTEs.

Results: Analysis of 3,007 referrals revealed that BPMH type and care setting were significant external determinants, while internal factors such as clinical pharmacology and geriatric psychiatry involvement prolonged completion times. While increases in total pharmacist and pharmacist technician FTEs reduced completion times April-Sept 2023 by 1 and 2 days, respectively, the effects diminished following an increase in clinical pharmacology capacity, clinical workflow and digital infrastructure adjustments.

Discussion: This study illustrates the dynamic interplay between external and internal factors on a clinical program's operational performance and how analysis of operational data can offer actionable insights for cost-effective improvements to health services for older adults.

Patellar Fractures in the Elderly Population: A Multi-Centre Retrospective Cohort Study

Jacqueline Brillantes[1], Joseph Di Michele[1], Graeme Hoit[1], Marko Gjorgjievski[2], Hyder Ali Khan[3], Jonathan Howatt[4], Bill Ristevski[2], David Wasserstein[5], Jennifer Watt[6], Emil Schemitsch[3], Prism Schneider[7], Allan Liew[4], Aaron Nauth[6].
[1]University of Toronto; [2]Hamilton Health Sciences; [3]London Health Sciences Centre Research; [4]Ottawa Hospital Research Institute; [5]Suunybrook Research Institute; [6]St. Michael's Hospital; [7]Foothills Medical Centre.

Background/Purpose: With an aging population, patellar fractures are increasingly common among older adults, yet optimal treatment and predictors of outcomes remain unclear. This study examined clinical features, treatment patterns, and outcomes of geriatric patellar fractures in Canada.

Method: This multi-center retrospective cohort review at six Canadian hospitals included patients >65 years treated for patellar fractures over 10 years, grouped by surgical or conservative treatment. Clinical and radiographic data were collected up to one-year follow-up. Descriptive statistics and multivariate logistic regression compared fracture healing outcomes, adjusting for relevant covariates.

Results: 932 individuals were identified, mean age 77.1 years (range 65-104), with 704 (75.54%) of fractures occurring in females. A majority (n=822, 88.2%) of fractures were due to falls, and a majority (n=616, 66.1%) were treated conservatively. Patients treated surgically had a higher rate of extensor mechanism disruption (p=<0.01) and a greater degree of fracture displacement (p=<0.01) at presentation. 74 (23.4%) patients treated surgically required reoperation. Symptomatic hardware was the indication for reoperation in the majority (n=50, 67.57%) of patients. A higher rate of medical complications occurred at 1 year (p<0.001) in the surgical group (18%) compared to the non-surgical group (3.4%), and more non-surgical patients (78.6%) returned to pre-injury ambulatory status (p<0.001) compared to surgical patients (67.4%).

Discussion: This study provides valuable insights into the nature and treatment patterns of geriatric patellar fractures in Canada. These are typically low-energy injuries and amenable to non-surgical treatment. Additional prospective investigations in this patient population are warranted to further optimize treatment strategies for patellar fractures.

Multidimensional Effects of Virtual Comprehensive Geriatrics Assessment (CGA) in Primary Care

Javier Cabrera.
Innovation in Dementia and Aging Lab / The University of British Columbia.

Background/Purpose: The aging population in Canada faces increasing challenges in accessing comprehensive healthcare, particularly frail older adults in primary care settings. Virtual Comprehensive Geriatric Assessment (CGA) offers an innovative solution to address these challenges. This study synthesizes evidence on the multidimensional effects of virtual CGA, including clinical, functional, mental, social, and diagnostic outcomes, to evaluate its feasibility and potential for improving care plans.

Method: A mini literature review was conducted using CINAHL and PubMed databases. Inclusion criteria focused on studies examining virtual CGA in primary care for individuals aged 60 and older. A total of 13 studies were screened, and 5 were included based on relevance and methodological quality. Outcomes assessed included clinical improvements, functional capacity, mental health, social well-being, and diagnostic feasibility.

Results: The findings highlight significant benefits across multiple dimensions. Virtual CGA improved clinical outcomes such as chronic disease management and frailty identification, enhanced functional mobility, and reduced fall risks. It also improved mental health outcomes, including reduced psychological stress and better cognitive assessments. Social outcomes included reduced caregiver burden and improved social connectedness. Diagnostic feasibility was high, with an 88.5% completion rate and significant influence on care plans. Virtual CGA sessions averaged 26 minutes, demonstrating practicality in primary care.

Discussion: Virtual CGA offers a feasible, efficient, and impactful approach to addressing the healthcare needs of frail older adults. Its multidimensional effects underscore its potential to enhance care equity, optimize resource allocation, and improve health outcomes in primary care. Future research should explore cost implications and standardization to maximize its utility.

Opportunities to Improve Communication with Older Adult Patients and Their Caregivers

Jeffrey Smith[1], Karen Pacheco[1], Elaine Rose[1], Tricia Savoy[1], Laura Payant[1], Catherine Bernard[1], Cathy Zhang[1], Katherine Lariviere[1], Genevieve Casey[2], Gary Garber[3].
[1]Canadian Medical Protective Association (CMPA), Department of Safe Medical Care, Ottawa, Ontario, Canada; [2]Faculty of Medicine, Department of Medicine, Division of Geriatric Medicine, University of Ottawa, Ottawa, Ontario, Canada; [3]Canadian Medical Protective Association (CMPA), Department of Safe Medical Care, Ottawa, Ontario, Canada; Faculty of Medicine, Department of Medicine and the School of Epidemiology and Public Health, University of Ottawa, Ottawa, Ontario, Canada; Faculty of Medicine, Department of Medicine, University of Toronto, Toronto, Ontario, Canada.

Background/Purpose: Older adult patients may have more complex care needs. Decisions about their care can involve authorized substitute decision-makers (SDMs). A physician's communication with patients and their SDMs can affect health

outcomes and satisfaction. Our study assessed communication issues between the physician and their older adult patients or SDMs that led to a medico-legal complaint.

Method: We performed a content analysis of criticisms of physician communication in Canadian medico-legal cases closed in 2018 to 2022 involving family medicine physicians caring for older adult patients (age 65+).

Results: From 338 cases involving 350 family physicians with criticism of communication with older adult patients or their SDMs, we organized 482 codes into five themes. Communication issues related to respect, demeanor, and active listening were the most common, followed by communication issues related to informed consent.

Discussion: Our content analysis identifies areas of communication issues that are important to rapport between the physician and the patient and their SDM, as well as for patient safety. Particularly, unclear or absent communication of medication risks and benefits were common amongst communication issues related to informed consent. Physicians and quality improvement teams would benefit from using the results of our content analysis to provide evidence-driven program development to improve physician communication with their older adult patients and their SDMs.

A Community Paramedicine and Specialized Geriatric Services Partnership: Implementation and Impact of an Innovative Model of Care

Jo-Anne Clarke[1], Julie Ward[2], Allison Hicks[3], Melanie Briscoe[1], Scott Infanti[2], Sara McEwen[4], Jason Prpic[5], Shaen Gingrich[4], Melissa Roney[6].
[1]Health Sciences North, North East Specialized Geriatric Centre; [2]Greater Sudbury Paramedic Service - Community Paramedicine Program; [3]Great Sudbury Paramedic Service – Community Paramedicine Program; [4]Health Sciences North - North East Specialized Geriatric Centre; [5]Health Sciences North; [6]Greater Sudbury Paramedic Service.

Background/Purpose: Since 2020, the North East Specialized Geriatric Centre (NESGC) and Greater Sudbury Paramedic Service – Community Paramedicine Program (CP) partnered to expand access to Specialized Geriatric Services and adapt the 911 system to serve older adults in the community. NESGC trained paramedics in geriatric assessment to identify and intervene on geriatric syndromes. They are supported by the geriatrics team, including an on-call geriatric specialist, access to SGS team members and joint visits. The objectives of this presentation are to: 1. Describe key enablers of success; 2. Outline the impact for patients and healthcare system.

Method: Through focused discussions and document review we outlined key enablers and impacts. We refined these through structured feedback with frontline clinicians and healthcare leaders.

Results: Key enablers were strong inter-service relationships and collaboration, the provision of specialized geriatrics training to CP, the development of direct referral pathways, access to patient history and current care plans, and a focus on proactive in-home care in real time. Impact for patients and families included improved access/continuity of specialized care, reduced caregiver stress, and receiving care at home. System impacts include pooled resources, improved care coordination, majority of patients receiving care at home (>80% of patients who call CP are treated at home, not transported), and enhanced job satisfaction.

Discussion: This collaboration was successful and sustainable, resulted in positive outcomes for patients and the healthcare system, and has been a model for spread elsewhere in Ontario. Additionally, it has served a model that CP has used to partner with other specialties.

Application of Lean Principles to the Comprehensive Geriatric Assessment

Junghyun Park[1], Eunice Lipinski[2], Pauline Fisher[2], Amanjot Sidhu[1].
[1]Hamilton Health Sciences, McMaster University; [2]Hamilton Health Sciences.

Background/Purpose: Prolonged cycle times for new geriatric medicine assessments at the Centre for Healthy Aging have reduced the capacity to see patients. Using a time series design, the aim of the project was to decrease the average cycle time for new patients during one geriatrician's clinic from 114 to 90 minutes by May 1, 2024.

Method: Lean methodology was used for diagnostics by creating a value stream map of the workflow. This informed change ideas to improve efficiency by implementing a shared note within the electronic health record for information sharing and an assessment guide for targeted cognitive testing. The primary outcome measure was total cycle time. Balancing measures were patient clinic experience scores and counseling time. Process measures included support person interview time, pre-clinic intake completion rate, assessment guide use rate, and nursing assessment time.

Results: Total cycle time decreased 19% from 114 minutes to 93 minutes. Pre-clinic intake assessment completion rate increased from 60% to 80% and support person interview time decreased from 45 minutes to 33 minutes. There was 100% uptake of the assessment guide use and nursing assessment time decreased from 43 minutes to 31 minutes. Counseling time remained stable and the average clinic experience scores did not decline from baseline.

Discussion: This is the first study examining potential methods to improve efficiency of the comprehensive geriatric assessment by using value stream mapping. Spread of the change ideas across the centre will be examined next with the goal of increasing capacity using available resources.

The Impact of Recreational Facilities on the Health and Well-Being of Older Adults in Calgary

Kareena Kassam[1], Dani Spady[2], Jacqueline M McMillan[3].
[1]University of Alberta, Medical Student, Alberta Health Services, Registered Nurse; [2]City of Calgary; [3]Division of Geriatric Medicine, Cumming School of Medicine, University of Calgary.

Background/Purpose: As the population ages, there is growing focus on older adults' ability to maintain their health and quality of life. Recreational facilities play a critical role in promoting physical, mental, and social well-being. However, limited research exists on the impact of these facilities on older adults' health and the barriers and facilitators to participation. This study investigated the values and opinions of older adults towards recreational facilities and barriers and facilitators to accessing these facilities in Calgary, Alberta.

Method: This cross-sectional observational study surveyed older adults aged ≥ 55 years who attended one of two City of Calgary-operated Aquatic & Recreation Centres between June 1 and July 15, 2024. Participants completed a structured survey assessing their demographic characteristics, patterns of facility use, perceived benefits and barriers to attendance, and suggestions for improving accessibility and engagement. Data were analyzed using descriptive statistics.

Results: A total of 152 participants completed the survey. The most frequently reported benefits were physical health (n=134, 93.1%), mental health (n=88, 61.1%), and improved strength and balance (n=63, 43.8%). Barriers to participation included scheduling conflicts (n=32, 44.4%), cost (n=17, 23.6%), and physical health limitations (n=15, 20.8%). Many participants suggested improvements to accessibility within facilities, more transportation options and affordable programming.

Discussion: Recreational facilities in Calgary provide significant physical, mental, and social health benefits for older adults. However, barriers such as cost, transportation, and scheduling conflicts limit participation. Addressing these barriers through improved accessibility and expanded program offerings may enhance engagement and promote healthier, more active lifestyles among older adults.

Assessing Caregiver Burden in Patients with Dementia in Singapore

Kaysar Mamun.
Singapore General Hospital.

Background/Purpose: To assess changes in caregiver burdens in different stages of dementia.

Method: In a geriatric medicine clinic over 6 months, all patients were assessed for cognitive impairment as well as caregiver burden. Basic demographic data was collected; caregivers were interviewed for corroborative information.

Results: 202 patients were seen in the clinic, average age 82 years, male 65 (32.2%), female 137 (67.8%), marital status: single 6 (3%), married 88 (43.6%), divorced 4 (2%), widowed 104 (51.5%); educational status: no formal schooling 99 (49%), primary education 64 (31.7%), secondary education 34 (16.8%) and tertiary education 5 (2.5%). Cognition: mean MMSE score was 12; 92 (45.5%) patients had early dementia, 91 (45%) had moderate dementia and 19 (9.4%) had advanced dementia. Most common behavior problem noted was delusions, present in 84 (41.6%) patients. Caregiver arrangements: Spouse as sole caregiver for 59 (29%) patients, other designated family members for 83 (41%) patients, maid alone for 55 (27%) patients, both family members and maids for 5 (2.5%) patients. Our observation shows behavior problems were seen more in patients with mild to moderate dementia and they also required domestic helpers more often than severe dementia patients.

Discussion: Patients with mild to moderate dementia tend to have high care needs thus requiring at least one designated caregiver. With rapidly aging population and low birth rates in Singapore, availing a reliable and dedicated caregiver will be a great challenge in near future. Hence, early detection and intervention in dementia will slow down further progression of disease and reducing high caregiver burden.

Is the Free-Cog a Test of Function in Dementia?

Selena P. Maxwell[1], Jodie L. Penwarden[2], Michael Sun[3], Maia von Maltzahn[1], Shanna Trenaman[4], Kenneth Rockwood[1].
[1]Geriatric Medicine Research, Nova Scotia Health; Division of Geriatric Medicine, Department of Medicine, Dalhousie University, [2]Geriatric Medicine Research, Nova Scotia Health; [3]Division of Geriatric Medicine, Department of Medicine, Dalhousie University; [4]Geriatric Medicine Research, Nova Scotia Health; College of Pharmacy, Dalhousie University.

Background/Purpose: The cognitive domain, executive function, is impaired in many neurodegenerative diseases. The Free-Cog is a brief screening test designed to integrate cognition and function. Here, we compare the executive function sub-score of the Free-Cog (FC-EF) with the routinely used Lawton-Brody Instrumental Activities of Daily Living (LB-IADL), Physical Self-maintenance Scale (PSMS), and the Amsterdam IADL (Am-IADL) questionnaire (the sole test where a higher score is worse).

Method: Patients were recruited from three memory clinics in Nova Scotia (n=299 records). Correlation between tests, predictive ability and discrimination regarding dementia diagnosis was assessed using Pearson correlation, logistic regression, and area under the receiver operating characteristic curve (AUROC).

Results: The FC-EF correlated moderately negatively with the Am-IADL (r=-0.58, 95% CI: [-0.68–-0.45], p<0.001), moderately positively with the LB-IADL (r=0.45, 95% CI: [0.33–0.56], p<0.001), and weakly with the PSMS (r=0.19,

95% CI: [0.05–0.32], p<0.01). Sex stratification produced similar results, however in females the FC-EF did not significantly correlate with the PSMS (p=0.06) A one-point increase in FC-EF (OR: 0.71, 95% CI: [0.60–0.84], p<0.001) and LB-IADL (OR: 0.77, 95% CI: [0.63–0.94], p<0.01) reduced dementia odds, while Amsterdam IADL increased odds (OR: 1.03, 95% CI: [1.02–1.05], p<0.001); PSMS was not significant. LB-IADL discriminated dementia best (AUROC=0.91), followed by FC-EF (0.75), PSMS (0.72), and Amsterdam IADL (0.65).

Discussion: FC-EF correlates well with other functional tests and is strongly associated with dementia diagnosis. However, its discriminatory ability is lower than LB-IADL, suggesting additional function- specific tests can still add value for dementia diagnoses.

Improving Equitable Access to Specialized Geriatric Services. Who Are We Missing and Why?

Helen Alemu[1], Katrina Piggott[2], Barbara Liu[2].
[1]University of Toronto; [2]University of Toronto, Sunnybrook Health Sciences Centre.

Background/Purpose: The Specialized Geriatric Services (SGS) at Sunnybrook Health Sciences Centre offers essential care to community-dwelling older adults. Data collected by the Regional Geriatric Program of Toronto demonstrates significant disparity in visitation rates across neighbourhoods and associated population profiles in the served catchment area. The study objective was to understand barriers that impact access to SGS.

Method: Semi-structured qualitative interviews were conducted with self-identifying representatives of local organizations and health providers. A standardized interview guide was developed in partnership with qualitative researchers and geriatricians. The interviews were recorded with permission using Otter transcription software, then coded in NVivo before undergoing thematic analysis.

Results: 10 interviews were conducted, averaging 30 minutes in duration. In total, 18 thematic codes were generated across the transcripts. Repetition of coding denoted appropriate saturation in the interview sample. Three key concepts were identified from these results, including "Narrow Focus", "Unprioritized Service", and "Geriatric and Community Care Divide".

Discussion: From the data presented, older adults from marginalized communities were less able and likely to access SGS due to the limited applicability of the services offered, paired with inadequate communication and disconnection from primary care. Unique challenges exist for patients from these communities, impacting their interaction with hospital-based programs. Inequitable access to specialized geriatric care is an emerging topic for older adults. In understanding these barriers, appropriate interventions can be implemented in order to address the gaps and improve healthcare access to all older adults.

Geriatrician Human Resources and Adults 65+ in Ontario: Changes, 2018–2024

Michael Borrie[1], Kiran Shu[2], Kelly Kay[3].
[1]Lawson Research Institute, London, Ontario, Canada; [2]Western University; [3]Provincial Geriatrics Leadership Ontario.

Background/Purpose: This study reassessed the geriatrician human resource and population increases between 2018- 2024 to see if the gap between the number of geriatricians needed and the supply gap, had decreased.

Method: The College of Physicians and Surgeons Ontario website was used to identify new geriatricians and those who had retired. Lead geriatricians and administrators in each Specialized Geriatric Services confirmed if any of the geriatricians were part-time equivalents (PTEs). The ratio of 1.25 geriatricians/10,000 adults 65+ was applied to determine the number needed.

Results: The number of geriatricians increased from 153 to 203 or 196.3 Full-time Equivalents (FTE). The population 65+ increased from 2.25 million (2016) to an estimated 2.96 million in 2024 for a number of geriatricians needed in Ontario of 369.6 resulting in a supply deficit of 173.3. In 9/14 LHINS, the number of FTE geriatricians had increased and the supply deficit decreased in 8 LHINs. In 4 LHINs the number of geriatricians had remained unchanged, and the supply deficit increased. In one LHIN the supply deficit was essentially unchanged. Retirements were 13 with 30 (14.8%) geriatricians continuing to work 40 years past their medical degree year. There were 63 new geriatricians with 51 trained in Canada and 12 from abroad.

Discussion: The number of geriatricians in the province has increased and despite the population increase the need-supply gap overall has decreased. LHINs that have recruited new geriatricians or retained geriatricians past anticipated retirement have seen in the supply deficit decrease. Despite improvements, geriatrician supply remains below optimal levels.

Collaborative Systems Design for Equity with Older Adults with Experiences of Homelessness

Lara Nixon[1], Jillian Alston[2], Don Baker[3], Elaine Boyling[1], Alesia Campbell[4], Denise Cloutier[5], Theresa Conroy[1], Lisa Diamond[6], Clare Fletcher[6], Jayna Holroyd-Leduc[7], Martina Kelly[1], Katelyn Lucas[8], Emma Mierau[9], Laura Pin[10], Natanya Russek[11], Rachel Weldrick[12], Karen Whiteman[13].
[1]Department of Family Medicine, Cumming School of Medicine, University of Calgary; [2]Division of Geriatrics, Department of Medicine, St. Michael's Hospital, Unity Health Toronto; [3]Department of Family Medicine,

University of Calgary; [4]Regional Geriatric Program, St. Michael's Hospital - Unity Health Toronto; [5]Department of Geography & Research Fellow, Institute on Aging and Lifelong Health University of Victoria; [6]The Summit at Quadra Village Long-term care, Island Health; [7]Department of Medicine, Cumming School of Medicine, University of Calgary; [8]Aboriginal Standing Committee on Housing and Homelessness; [9]Community Health Sciences, Cumming School of Medicine, University of Calgary; [10]Political Science Department Wilfred Laurier University; [11]University of British Columbia, Geriatric Medicine Fellow; [12]Department of Health, Aging & Society, McMaster University; [13]Alberta Elder Abuse Awareness Council.

Background/Purpose: Older people with experiences of homelessness (OPEH) are a growing population who are underserved within current care structures. Existing services are vulnerable to political fluctuations and short-term funding cycles. This study convened experts in evidence-based, humanizing practice, to support knowledge exchange and action promoting inclusive, sustainable care systems that improve quality of life and equity with OPEH.

Method: Coresearchers are a diverse transdisciplinary team (n=17) with experience across the continuum of care (including lived experience as OPEH, care provision, education and training, management, and policy), located across Canada. We used collective inquiry to generate and disseminate knowledge through a series of team knowledge sharing events and the process of developing outputs. These include reports, policy briefs, infographics, and a program of strategic collaborative national conference sessions that facilitated interaction with diverse audiences, gathering qualitative and quantitative feedback through surveys and building a mailing list for future collaboration and knowledge exchange.

Results: This work has generated: (1) systems mapping of the current landscape in which services with OPEH are operating; (2) shared principles that guide equity-oriented services with OPEH; (3) strategies and tools for capacity-building and advocacy; and (4) priorities for future collaborative work.

Discussion: While OPEH currently experience inequitable access to health and wellbeing, there is a wealth of expertise and experience in developing feasible service responses that address this inequity. Our findings suggest that collaborative systems design that connects policy, practice, and lived experience, can promote efficient mobilization of resources for practice that prioritizes OPEH health equity.

Frailty-Specific Communication in Practice: Prioritizing Information and Clinician Recommendations to Empower Decision-Making

Laurie Mallery[1], Anne-Marie Krueger-Naug[1], Ashley P. Miller[1], Paige Moorhouse[1], Maia Von Maltzahn[1], Amanda Tinning[1], Nabha Shetty[1].
[1]Dalhousie University.

Background/Purpose: Frailty is often associated with a progressive illness trajectory and poor prognosis. A frailty-specific communication guideline (Mallery et al., 2024) outlines six steps for discussing serious illness: 1. Prioritize preparation; 2. Open the dialogue; 3. Share information; 4. Guide decision-making; 5. Support values-based decisions; 6. Ensure understanding.

Method: The framework is applied to a patient scenario. An 82-year-old man with moderate-stage dementia was hospitalized for one month due to heart failure. Despite receiving guideline-directed medical therapy, he remained fluid overloaded and short of breath at rest. His hospital course was complicated by hypoactive delirium, poor oral intake, and impaired mobility requiring assistance for ambulation.

Results: The guideline structured the discussion, as follows: 1. The clinician reviewed the medical history, gathered collateral information on baseline cognition, function, and mobility, and performed cognitive testing. They noted progressive symptoms, advanced frailty-related conditions, impaired decision-making capacity, and poor prognosis. 2. A care planning discussion with the patient's son outlined the purpose of the conversation—to review his father's medical conditions, prognosis, and care options. 3. Detailed information was provided about each medical condition and the patient's poor prognosis. 4. The clinician explained that despite intervention, his father's health status and symptoms would continue to worsen. Comfort-focused care was recommended. 5. The son chose to prioritize palliative care. 6. The clinician confirmed the son's understanding that his father was nearing the end of life and reviewed specifics of the palliative strategy.

Discussion: Frailty-focused communication ensures decision-makers receive honest information, understand prognosis, and align care plans with realistic goals.

Navigating Complex Care for Older Women with HIV: Role of Geriatrician Support

Luxey Sirisegaram.
Sinai Health.

Background/Purpose: As the population with HIV ages, older women (aged ≥50 years) living with HIV face unique challenges due to the intersection of aging, gender, and HIV-related factors. These challenges necessitate a nuanced, multidisciplinary approach to care. This study aimed to explore the application of the 5-Ms framework—Mind, Mobility, Medications, Multimorbidity, and what Matters Most—developed in geriatric medicine to address the diverse needs of this population, incorporating insights from interviews with older women living with HIV.

Method: A qualitative study was conducted involving interviews with nine cisgender and transgender women aged ≥50 years living with HIV. Data were analyzed to understand the medical, psychosocial, and functional challenges they face.

Findings were contextualized using the 5-Ms framework to propose tailored care strategies

Results: Findings revealed significant cognitive vulnerabilities, including impairments in attention, memory, and psychomotor speed. Mobility issues, such as sarcopenia, low bone density, and increased fall risks, were prevalent, exacerbated by HIV therapies and substance use. Polypharmacy, hyperpolypharmacy, and multimorbidity posed substantial challenges, with adverse outcomes such as falls, cognitive decline, and drug interactions. Participants emphasized the importance of person-centered care, addressing stigma, sexual health, and their lived experiences.

Discussion: Geriatricians, in collaboration with multidisciplinary teams, are uniquely positioned to tailor care, reduce medication-related risks, and enhance quality of life. Applying the 5-Ms framework can optimize health outcomes by addressing their medical, psychosocial, and functional needs, ensuring equitable, tailored care for this underserved population.

Frailty as an Outcome Measure of Slow-Stream Rehabilitation: Prospective Cohort Study Using the Fit-Frailty App

Maeve Conroy[1], Aastha Relan[1], Courtney C. Kennedy[1], George Ioannidis[1], Patricia Hewston[1], Jessica B. Crawford[1], Justin Lee[1], Lauren O'Malley[1], Mimi Wang[1], Mona Sidhu[1], Tricia Woo[1], Sabina Keen[1], Brian Misiaszek[1], Teshan D. Desinghe[1], Elisabeth Rubenschuh[2], Sarah Warcholak[2], Sylvia McLeod[2], Suleman Tariq[3], Alexandra Papaioannou[1].
[1]McMaster University; [2]Hamilton Health Sciences; [3]University of Toronto.

Background/Purpose: While frailty is known to be dynamic, evidence for its use to measure clinically meaningful treatment response is limited. Measuring frailty in clinical settings could inform decision-making and longer-term management. This study aimed to evaluate the effect of slow-stream rehabilitation on change in multidimensional frailty.

Method: The Fit-Frailty App is a validated, interactive frailty assessment incorporating multiple domains (e.g., disease-related, physical, cognitive, mood/psychosocial, nutritional, activities of daily living [ADL]). An overall score using the frailty index approach is computed and subdomain deficits summarized. A convenience sample of adults ≥65 years admitted to a slow-stream rehabilitation unit in Hamilton, ON was recruited between Mar-Sep 2024. Research assistants administered the Fit-Frailty App ≤3 days after admission and ≤3 days before discharge. Paired t-tests compared total and sub-domain Fit-Frailty scores at these timepoints. The clinically meaningful change threshold in Fit-Frailty score is ≥0.03 with p ≤0.007 (Bonferroni correction) considered statistically significant.

Results: Our sample (n=52) was 58% female, with mean age (standard deviation) 80.1(8.9) years and severe frailty on admission 0.45(0.08). Of approached patients, 84% consented and 12 were lost to follow-up. Most common primary diagnosis was fracture and mean length of stay was 55.7(24.9) days. The mean improvement in Fit-Frailty scores at time of admission compared to discharge was clinically meaningful -0.10(0.09)(p<0.001) and sub-analyses demonstrated the most significant improvement in the ADL domain(p<0.001).

Discussion: The Fit-Frailty App captured significant, clinically meaningful improvement in frailty following rehabilitation, with the largest effect on the ADL sub-domain. Result profiles could be used to enhance interventions and facilitate successful discharges.

Patterns of Antipsychotic Dispensing in Nova Scotia Seniors' Pharmacare Beneficiaries

Maia von Maltzahn[1], Alexandra M Yip[2], Sam Stewart[3], Hala Tamim[4], Ingrid Sketris[2], Shanna Trenaman[2].
[1]Division of Geriatric Medicine, Department of Medicine, Faculty of Medicine, Dalhousie University; [2]College of Pharmacy, Faculty of Health, Dalhousie University; [3]Department of Community Health & Epidemiology, Faculty of Medicine, Dalhousie University; [4]School of Kinesiology and Health Science, Faculty of Health, York University.

Background/Purpose: Potentially inappropriate prescribing of antipsychotics is a common concern in the care of older adults. The purpose of this retrospective cohort study was to examine patterns of antipsychotic dispensations amongst older adults in Nova Scotia, Canada.

Method: Administrative health data were obtained for all antipsychotic prescriptions funded by the Nova Scotia Seniors' Pharmacare Program (NSSPP) to eligible beneficiaries aged 65 years and older between January 1, 2009, and December 31, 2022. The type of antipsychotic received (ATC code) was retrieved, along with prescription duration. Patient (age, sex, Long Term Care (LTC) status, rurality, county) and prescriber (discipline) information were extracted. Denominators for rates were provided by StatsCan.

Results: There were 807,107 total antipsychotic dispensations for 26,099 unique beneficiaries, with dispensation rate ranging from 5.8%-6.4%. Second generation antipsychotics represented the majority of dispensations in each year of study (68% in 2009 to 80% in 2022). The most dispensed antipsychotics were consistent over time, though total prescription rates did vary. Quetiapine was the most frequently dispensed antipsychotic (29% of prescriptions in 2009, 40% in 2022), followed by risperidone, which decreased in frequency during the study period (31% to 22%). Olanzapine (8% up to 12%) and Haloperidol (approximately 7% throughout) followed in frequency.

Discussion: There was a change from first- to second-generation dispensations over the 14 years of study, but overall antipsychotic dispensation rates were consistent over time.

Quetiapine had the most notable increase in dispensation rate during the study, indicating a need for further research and education into its potential uses.

Development of Standardized Delirium and Dementia-Friendly Mobile Comfort Carts to Increase Senior-Friendly Non-Pharmacologic Care

Matteen Pezeshki[1], Arianna Paolone[2], Christina Sanders[3], Patricia Ford[3], Shari Duxbury[3], Leanne Nightingale[3], Susy Marrone[3], Joye St. Onge[3], Heather McLeod[3], Micheline Gagnon[3], Michele Patterson[3], Julian Li[4], Shawn Mondoux[3], Donna Johnson[3], Jane Loncke[3], Justin Lee[5].
[1]Western University, London, Canada; [2]Royal College of Surgeons in Ireland, Dublin, Ireland; [3]St. Joseph's Healthcare Hamilton, Hamilton, Canada; [4]McMaster University, Hamilton, Canada; [5]Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Canada; Centre for Integrated Care, St. Joseph's Health System, Hamilton, Canada; GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada.

Background/Purpose: Hospital environments can be harmful to older adults and contribute to hospitalization-associated disability. To improve health outcomes, guidelines recommend more focus on non-pharmacological care to better address physical, emotional, cognitive, and rehabilitative needs of older adults. We sought to develop the use of standardized mobile '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.

Method: In this study, we conducted stakeholder consultations with patients, clinicians, hospital administrators, and hospital volunteers of an academic hospital to inform intervention design. Surveys were conducted to understand stakeholder attitudes and perceptions of non-pharmacological care.

Results: We surveyed 144 healthcare workers, patients, and volunteers. Over 94% of healthcare workers considered non-pharmacological care as essential for patient care. Nearly half reported having no non-pharmacological care training, and of those that did receive training, 50% reported it to be insufficient. The top cited barriers to providing non-pharmacological care included lack of time and resources, while the top cited facilitators included a non-pharmacological care team, standardized item inventory, and central resource location. Most patients reported that the current care they receive in hospital did not meet their expectations for meeting their basic sensory, stimulatory and social needs for recovery in hospital. Non-pharmacologic care was identified as essential for both high-quality and compassionate patient care.

Discussion: Non-pharmacologic care is an important unmet care need for older adults. A standardized mobile 'Comfort Cart' program, designed using this feedback, could improve the overall hospital experience of older adults.

Defining Trafficking of the Elderly

Natalya Timoshkina.
School of Social Work, Lakehead University Orillia.

Background/Purpose: Trafficking of the elderly (TOE) occurs globally but remains hidden and unresearched. The main purpose of the study from which findings are presented here was to develop a working definition of this phenomenon.

Method: The Delphi methodology was employed by the study. Two rounds of online survey were administered to a Delphi panel of 54 Canadian experts on aging and trafficking in persons (TIP). First, they were presented with eight cases of elder mistreatment and asked to rate the degree to which each case conformed to the key elements of the United Nations (2000) definition of TIP (acts, means, purpose) on a five-point scale. Then the experts were tasked with choosing one of three possible TOE definitions based on the themes distilled in the first round. Consensus on the TOE definition was achieved when 80% of the participants agreed.

Results: The proposed definition conceptualizes TOE as a distinct category of TIP, wherein persons aged 65+ are specifically targeted for the purpose of exploitation because of the actual or perceived vulnerability associated with their old age. The examples of exploitation include: certain forms of financial exploitation; forced criminal activity; forced begging; domestic servitude and other forms of forced labour; and sexual exploitation.

Discussion: This was the first known study on TOE. As the world's population ages, the number of trafficked elderly is expected to increase. TOE thus requires further, in-depth exploration by scholars, and closer attention from practitioners and the general public.

Frailty and Comprehensive Geriatric Assessments in Primary Care: A Qualitative Study

Olga Theou[1], Yanlin Wu[2], Madeline E Shivgulam[1], Myles W O'Brien[3], Elaine Moody[1], Barry Clarke[1].
[1]Dalhousie University; [2]Nova Scotia Health; [3]Université de Sherbrooke and Centre de Formation Médicale du Nouveau-Brunswick.

Background/Purpose: Frailty is one of the most challenging aspects of population aging, but it can be managed using Comprehensive Geriatric Assessment (CGA) in primary care settings. It is unclear how well the public understands frailty and how primary care providers perceive the integration of CGA to address it. The purpose of this study was to explore patients' and providers' diverse perceptions of frailty and use of CGA, and identify the barriers and facilitators to implementing an electronic CGA (eCGA) in primary care.

Method: A total of 11 patients ≥65 years (7 females) and 13 providers with >6 months of professional experience (5 general practitioners, 5 nurses, 3 nurse practitioners; 12 females)

completed a remote (n=15) or in-person (n=9) semi-structured interview. Topics included participants' understanding of frailty, their experiences with aging-related care in primary settings, patients' preferences for interactions with providers regarding aging, and providers' views on the barriers and facilitators to implementing eCGA in primary care.

Results: Thematic analysis revealed that both patients and providers value frailty assessments, however, most patients had never discussed frailty with their primary care providers. Providers identified lack of time, education, and support as the primary barriers to integrating CGA into primary care. Alternatively, providers perceived training, compensation, clinical champions, and a user-friendly interface as key facilitators for implementing the eCGA.

Discussion: Frailty is an under-addressed but important issue in primary care. These findings can support the successful development and implementation of eCGA into primary care to improve frailty care.

Ischemic Heart Disease Presentation at Different Ages in the Manitoba Follow-up Study

Joëlle Bourgeois-Gosselin[1], Philip St. John[1], Robert Tate[1].
[1]University of Manitoba.

Background/Purpose: The Manitoba Follow-up Study (MFUS) is the longest running prospective cohort study of cardiovascular disease and aging in Canada, allowing a life course analysis of disease. This study aims to 1. To identify how ischemic heart disease (IHD) presents at different ages in MFUS; and 2. To explore the risk of developing a myocardial infarction (MI), or sudden cardiac death (SCD) after a diagnosis of angina.

Method: In 1948, 3983 men who qualified for air crew training in the RCAF and were free of heart disease were enrolled in MFUS. Of those, 1506 developed ischemic heart disease (IHD), defined as a clinically evident MI, angina pectoris, or sudden unexpected cardiac death (SUCD). Medical records were reviewed and coded by study physicians. Initial manifestations of heart disease were determined using the same diagnostic codes throughout the study. Age-specific incidence rates were calculated for each of these outcomes.

Results: The overall incidence of IHD increased with age. Prior to age 45 years, IHD was uncommon. In midlife (age 45-65), angina and MI were common initial presentations of IHD. After the age of 75, MI was a more common initial presentation of IHD, whereas the incidence of angina as the initial manifestation of IHD decreased. SUCD as an initial presentation of IHD increased steadily with age. Those with angina are at a high risk of MI and SCD.

Discussion: Younger men are more likely to present with angina than older men in MFUS. With advancing age, MI and SUCD are more common manifestations of IHD.

Exploring Factors Influencing the Adoption and Use of Health Technology for HIV Management Among Older Adults Living with HIV: A Qualitative Study

Kristina Kokorelias[1], Erica Dove[1], Dean Valentine[1], Paige Brown[2], Stuart McKinlay[2], Andrew Eaton[3], Esther Su[1], Christine Sheppard[2], Laura Jamieson[1], Marina Wasilewski[4], Hardeep Singh[2], Alice Zhabokritsky[5], Reham Abdelhalim[2], Rabea Parpia[6], Rahel Zewude[2], Sharon Walmsley[5], Luxey Sirisegaram[1].
[1]Sinai Health; [2]University of Toronto; [3]University of Regina; [4]St. John's Rehab; [5]University Health Network; [6]Regent Park CHC.

Background/Purpose: Despite the potential of health technologies to support self-management and improve health outcomes, their adoption and use among older adults living with HIV remain limited. This study explored the factors influencing the adoption and use of health technologies for HIV management in older adults to inform strategies for improving the accessibility and effectiveness of these tools.

Method: A qualitative descriptive study, guided by the Theoretical Domains Framework, was conducted from November 2023 to April 2024. Fourteen adults living with HIV H (mean age 58.7 years) participated in interviews. Participants, predominantly men (71%) and immigrants (57%), discussed their experiences with health technologies. Data were analyzed to identify barriers and facilitators to technology adoption and use.

Results: Participants highlighted both barriers and facilitators to technology adoption. Key themes included: (1) Self-management: Technology enabled self-care and information-seeking but was often used to avoid stigmatized healthcare encounters. (2) Practical considerations: Barriers included affordability, language, and cognitive challenges, while simple, intuitive designs facilitated use. (3) Perceived usefulness and ease of use: Perceptions of value, privacy, and usability influenced adoption. (4) Social influences: Peer experiences significantly shaped attitudes toward technology.

Discussion: Findings highlight the need for user-centered design that accounts for affordability, linguistic inclusivity, and cognitive accessibility. Transparent consent processes and community-driven approaches can enhance trust. Tailored, inclusive health technologies addressing the unique needs of adults living with HIV can reduce stigma, promote self-management, and improve health outcomes. Insights from this study inform the development of equitable digital health solutions for this vulnerable population.

Characteristics, Barriers, and Facilitators of Virtual Decision-making Capacity Assessments During the COVID-19 Pandemic

Lesley Charles[1], Eileen Tang[1], Peter George Tian[1], Karenn Chan[1], Suzette Brémault-Phillips[2], Bonnie Dobbs[1], Camelia Vokey[1], Sharna Polard[3], Jasneet Parmar[1].

[1]Division of Care of the Elderly, Department of Family Medicine, University of Alberta; [2]Department of Occupational Medicine, University of Alberta; [3]Library Services, Covenant Health.

Background/Purpose: With a growing elderly population, the number of persons with dementia is expected to rise. Consequently, the number of persons needing decision-making capacity assessments (DMCA) will increase. The COVID-19 pandemic has impacted how we deliver patient care including DMCAs. The objective of this study was to determine the characteristics, barriers, and facilitators of conducting virtual decision-making capacity assessments during the COVID-19 pandemic.

Method: We conducted an online survey among healthcare providers who perform DMCAs in Alberta from March 2022 to February 2023. The survey consisted of 25 questions on demographics, preferences, and experience in conducting DMCAs virtually, and risks and barriers to doing virtual DMCAs. The data was analyzed using descriptive statistics.

Results: There were 31 respondents with a mean age of 51.1 years (SD: 17.7). The respondents consisted of physicians (45.2%), occupational therapists (29.0%) and social workers (16.1%), with a majority (93.6%) based in Edmonton. 54.8% were interested in conducting DMCAs virtually; however, only 25.8% had administered DMCAs virtually. Barriers and facilitators to virtual DMCAs relate to patients' characteristics and environment, technology and technical support, and assessors' ability to perform DMCA's virtually. In terms of implications for clinical practice it is recommended that the patient or caregiver be familiar with technology, have a stable internet connection, utilize a private room, not be recorded, utilize standardized assessment template and have a back-up plan in case of technical difficulties.

Discussion: Conducting DMCAs virtually is a relatively infrequent undertaking. Barriers and facilitators to adequate assessment need to be addressed.

Bidirectional Longitudinal Relationship Between Multimorbidity and Depression in Middle-aged and Older Adults: A Cross-lagged Panel Analysis

Man-Man Peng[1], Zurong Liang[2], Pengfei Wang[3].
[1]Department of Social Work, The Chinese University of Hong Kong, Hong Kong SAR; [2]Department of Sociology, Zhejiang University; [3]Department of Health Sciences, University of York, York, UK.

Background/Purpose: This longitudinal study aims to investigate the bidirectional relationship between depressive symptoms and multimorbidity over time in middle-aged and older Chinese adults.

Method: Using five-wave data from the China Health and Retirement Longitudinal Study (CHARLS) from 2011 to 2020, the analytic sample included 8692 middle-aged and older adults. Depressive symptoms were measured using the Center for Epidemiologic Studies Depression Scale (CES-D), and multimorbidity was conceptualized as having two or more chronic physical diseases. When adjusting for covariates, the Cross-Lagged Panel Models (CLPM) were used to examine the associations between multimorbidity and depression over the nine years. In-depth subgroup analysis was conducted by gender and hukou: urban males, urban females, rural males, and rural females.

Results: Of the 8692 participants, a significant trend was observed in longitudinal associations between multimorbidity and depression, with gender and rural-urban variations. Specifically, rural males and females demonstrated a significant bidirectional relationship between multimorbidity and depression, with rural females showing a more pronounced trend. After adjusting for sociodemographic and other control variables, a higher frequency of depressive symptoms at the follow-up (2020) was found to be significantly associated with an increased risk of multimorbidity at baseline (2011).

Discussion: Having multimorbidity significantly predicted depression over time in middle-aged and older adults in China, especially in rural areas. Depression significantly increased the risk of developing or worsening multimorbidity. These findings provide important insights into the bidirectional relationship between depression and multimorbidity, which can help healthcare providers design interventions to mitigate the impact of chronic diseases.

Dementia Dashboard: The "Check Engine" Light is On! Showing the Impact of Patients Living with Dementia on Key Hospital Metrics

Marice Prior[1], Frank Molnar[2], Jennifer Koop[3], Matthew A Sacheli[1], Courteney Munch[3], Nadine Sebahana[2], Meghan Kelly[2], Allen R Huang[4], Tammy Pulfer[1].
[1]Regional Geriatric Program of Eastern Ontario; [2]The Ottawa Hospital; [3]Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital; [4]Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital, University of Ottawa.

Background/Purpose: Patients living with dementia (PLWD) face disproportionate challenges in acute care, including extended emergency department stays, higher hospitalization rates, longer lengths of stay, and elevated rates of harm. These issues are exacerbated by health system pressures, such as alternative level of care (ALC) bed occupancy and human resource challenges.

Method: A multidisciplinary committee at The Ottawa Hospital (TOH) was formed to address these challenges. The team defined the PLWD population using health records, coding data, and literature. A dementia scorecard was developed, mirroring the leadership corporate scorecard which included measures of patient experience, value of care (cost per case), health of populations (ALC length of stay) and patient safety

(mortality and adverse health events). The goal was to display the impact of PLWD on key hospital indicators. This tool evolved into a live dashboard, involving input from experts in analytics and clinicians.

Results: When the dashboard went live with quarterly data, it showed an initial prevalence of 3.7% for hospital PLWD, which confirmed a clear under-reporting. However, these patients accounted for 35% of ALC days, incurred double the cost per case, and experienced 1.6 times higher adverse event rates.

Discussion: The results seen in the dashboard provided feedback to improve the capture of PLWD within the Electronic Medical Record by encouraging all clinicians to record "dementia" or synonyms within the diagnosis list. This tool is crucial for the ongoing support of hospital leadership in the implementation of the Dementia Decoded: Acute Care Dementia Strategy to enhance person-centered care for this vulnerable population.

Movement as Medicine: Dance-based Rehabilitation for Older Adults in Hospital

Patricia Hewston[1], George Ioannidis[1], Caroline Marr[2], Courtney Kennedy[1], Sharon Marr[3], Teshan Dias[1], Alexandra Papaioannou[1].
[1]McMaster University; [2]University of Toronto; [3]Unity Health.

Background/Purpose: Hospitalized older adults are at risk for significant functional decline due to inactivity, losing up to 10% of muscle mass within the first week of bedrest. This can lead to declines in mobility, independence, and overall quality of life. The goal of this quality improvement (QI) project was to assess the feasibility and process of implementing GERAS DANCE On-Demand, a video-based rehabilitation program, to engage hospitalized older adults in rehabilitation activities.

Method: The program was deployed across six inpatient units in four mid-sized urban hospitals in southwestern Ontario. Staff received a 30-minute training session, and each intervention setup required less than 5 minutes using readily available equipment (e.g., TV, laptop, or projector). The PDSA (Plan-Do-Study-Act) cycle was used to guide implementation, providing a structured process for continuous refinement.

Results: The program was successfully implemented with older adults recovering from surgery, managing chronic conditions, regaining function after illness, or living with dementia. In the plan phase, staff capacity and equipment needs were assessed, leading to tailored training. In the do phase, sessions were conducted in various settings, including patient beds, chairs, and group activity rooms. During the study phase, pilot testing revealed strong organizational support, a user-friendly online portal, and the motivational effect of 1950s-1960s music. In the act phase, volunteers were recruited to help with group sessions, enabling larger groups of participants.

Discussion: GERAS DANCE On-Demand was feasible as a senior-friendly rehabilitation program for hospitalized older adults across diverse care settings. Future work will evaluate functional outcomes and fidelity across care settings.

What Gets Counted, Counts: Paying Attention to Sex and Age in Health Research

Joyce Li[1], Paula Rochon[2], Robin Mason[3].
[1]Women's Age Lab, Women's College Hospital; [2]Founding Director, Women's Age Lab, Women's College Hospital, Professor, Department of Medicine and Dalla Lana School of Public Health, University of Toronto; [3]Women's College Hospital.

Background/Purpose: Disaggregating data by sex, age, and gender uncovers potential differences and similarities between the sexes and across the lifespan that are important to address health inequities experienced by older adults and other vulnerable populations. Despite this, health researchers often consider those 65+ years as a single cohort, making these sex, age and gender distinctions invisible. Our objective was to develop an educational tool to enhance investigators' understanding of sex and age, why disaggregating data by sex and age is important, and how to apply that understanding to their work.

Method: Drawing on the literature and input from Anglophone and Francophone patient partners, an asynchronous interactive e-module with case examples was developed in English, then translated to French along with a downloadable handbook.

Results: "What gets counted, counts: Paying attention to sex and age in health research" is an interactive, engaging and informative module for anyone involved in health research. A comprehensive, multi-pronged communications strategy was created to widely disseminate the module.

Discussion: Sex, age, and gender are critical to designing robust studies and advancing equitable, diverse and inclusive research methods. An evidence-informed, interactive and accessible e-learning module can address this knowledge gap and highlight the importance of considering intersections of sex, age, and gender. When the intersection of sex, age, and gender is overlooked, information is missed that could result in the oversimplification or misrepresentation of study results. Module completion can enhance knowledge of how to integrate sex, age, and gender in research thereby improving the quality and development of equitable care.

Developing an Approach to Virtual Care for Older Adults

Pauline Wu[1], Jennifer Watt[2], Erika Dempsey[1], Zahra Goodarzi[1].
[1]University of Calgary; [2]University of Toronto.

Background/Purpose: COVID-19 exemplified the need to adapt and update ways of assessing patients. For older adults,

barriers to accessing in-person care during the pandemic limited access to quality care and management of their health. Virtual care provides a potential solution to addressing this gap in care if appropriately adapted for this demographic.

Method: We completed a virtual, modified Delphi procedure to create an approach to providing virtual care for older adults to enhance healthcare provider, patient, and care-partner experience. We used a mixed-methods approach including quantitative (median and interquartile range) and qualitative (thematic analysis of panelist comments) data. Those who completed ≥80% of each round were included in analyses. Key experts included healthcare providers from various backgrounds, healthcare leadership, patients, and care partners.

Results: Sixty-two panelists completed round one. Panelist feedback was incorporated into round two. Eighteen (29.0%) panelists submitted complete responses for round two. The finalized approach consisted of 20 statements across four domains: virtual care principles (n= 7), pre-clinic assessments (n= 4), during each virtual assessment (n= 7), and clinic processes for virtual assessment (n= 2).

Discussion: In an environment where virtual care may be necessary and a promising opportunity for older adults, it must be acknowledged that it does not replace in-person care and barriers may exist to optimal employment. The approach resulting from this work highlights the importance of preparation.

Conclusion: Using this approach, healthcare providers and patients can plan ahead to bridge the gap present in in-person care.

Place of Death of Older Canadians

Philip St John[1], Cara Brown[1], Genevieve Thompson[1], Shahin Shooshtari[1], Lauren Griffith2, Kerstin Roger[1], Scott Nowicki[1], Robert Tate[1].
[1]University of Manitoba; [2]McMaster University.

Background/Purpose: 1. To determine the place of death of Canadians aged 65+; and 2. To determine the predictors of location of death.

Method: We conducted an analysis of the decedent questionnaire of the Canadian Longitudinal Study on Aging (CLSA). The CLSA is a prospective cohort study of aging which commenced in 2010, with a sample of 51,338 community-living participants aged 45 to 85. There were 1287 participants with proxy completed decedent questionnaires. Of these, 1139 were over the age of 65 at the time of death and had complete data. For these analyses, Community was defined as the participant's home or non-health care settings. Other locations were: Hospice/Palliative care, Hospital, and Nursing Home/Residential (long term care – LTC) setting. Age, sex, and income were from the CLSA survey. Functional trajectory prior to death was from the proxy report of the decedent questionnaire. We conducted bivariate analyses to determine factors associated with the place of death.

Results: 24% died in the Community, 50% died in Hospital, 16% died in Hospice/Palliative Care, and 10% died in LTC. Of those who died in LTC, most were over 85. Those who had a sudden death were more likely to die in hospital (48%) or community (46%). Those with a terminal illness trajectory were more likely to die in hospital (46%) or hospice/palliative care (27%). Those with a gradual decline were more likely to die in hospital (48%) or LTC (22%).

Discussion: Multiple factors are associated with the place of death.

Frailty Outcomes in Adults Following Prolonged Bed Rest and Recovery

Olga Theou[1], Joanna M Blodgett[2], Judith Godin[1], D. Scott Kehler[1], Susan E. Howlett[1], Kenneth Rockwood[1].
[1]Dalhousie University, Halifax, Nova Scotia, Canada, [2]University College, London, UK

Background/Purpose: Prolonged bed rest during hospitalization is a common yet underrecognized contributor to adverse health outcomes in older adults, exacerbating frailty and delaying recovery. The purpose of this study was to investigate how frailty changes during bed rest and subsequent recovery and to investigate if an exercise intervention can counteract against any changes.

Method: Twenty-two healthy people, aged 55 to 65 years, participated in a randomized controlled trial that included a control group (n=11, 5 females, 58.4±3.9 years) and an exercise group (n=11, 6 females, 58.4±3.4 years). All participants spent 14 days in complete head-down tilt position followed by a 7-day recovery period, and 4-week and 4-month follow-up assessments. The exercise group participated in three daily sessions that included high-intensity interval training, aerobic activity, and strength training. We measured frailty using a frailty index at 10 timepoints throughout the study.

Results: Overall there was an increase in frailty from 0.02±0.02 at baseline to 0.04±0.03 at 4-month follow-up (p=0.005); however, there was no difference (interaction term: p=0.63) between groups (Control: 0.02±0.01 to 0.04±0.03; Intervention: 0.01±0.02 to 0.03±0.036). Frailty increased during bedrest (0.005 increase/day), and decreased during the recovery, although it did not return to baseline levels even after four months of follow-up. There was evidence that those who exercised had lower frailty levels during the immediate 7-day recovery period.

Discussion: This study provides critical insights into how bed rest can impact frailty and how exercise may serve as effective countermeasure in healthy middle-aged adults.

Understanding Care for Depression in Long-term Care

Kayla Atchison[1], Grace Lew1, Dallas Seitz[1], Matthias Hoben[2], Andrea Gruneir[3], Jennifer A Watt[4], Patrick Quail[1], Zahinoor Ismail[5], Jayna M Holroyd-Leduc1, Vivian Ewa[6], Jennifer Knopp-Sihota[7], Peter Faris[8], Marie-Andree Bruneau[9], Loralee Fox[8], Carole Estabrooks[3], Jason Sutherland[10], Zahra Goodarzi[1].
[1]University of Calgary; [2]York University; [3]University of Alberta; [4]University of Toronto; [5]University of Calgary; Hotchkiss Brain Institute; O'Brien Institute for Public Health; [6]University of Calgary; Alberta Health Services; [7]Athabasca University; [8]Alberta Health Services; [9]University of Montreal; [10]University of British Columbia.

Background/Purpose: Over 40% of persons living in long-term care in Canada experience depression. There is a need to create a care pathway that outlines steps to best detect, diagnose, and treat depression in the long-term care setting.

Method: Interviews were completed with long-term care residents, care-partners, health care providers, and managers to understand the barriers and facilitators to providing care for depression in the long-term care setting. Framework analysis methods utilizing the Theoretical Domains Framework were used to analyze the interview data. Interviews were coded and each code was labelled as a barrier or facilitator to depression care. Overarching themes were identified from the codes.

Results: Themes identified from interviews included resident-specific needs like the impact of cognitive impairment and identifying the root cause of depression, the importance of a team-based approach to care for depression and providing resident-centered care, and the availability of resources such as access to specialized services and tools to detect and monitor depressive symptoms.

Discussion: There is a need to prioritize care for depression by increasing knowledge of depression presentation and treatments, and provide patient-centered care for depression within the long-term care setting to improve quality of life for residents. Access to non-drug interventions is challenging, and mixed evidence on drug treatments hampers management. Understanding the barriers and facilitators to depression care is a critical step towards implementing evidence informed care for depression in long-term care.

"It's like it's the old boys club"—The Age-related Experiences of Diverse Older Women Living with HIV: A Scoping Review and Consultative Exercise

Kristina Kokorelias[1], Esther Su[1], Paige Brown[2], Stuart McKinlay[2], Sharon Walmsley[3], Alice Zhabokritsky[3], Katie Lee[2], Luxey Sirisegaram[1].
[1]Sinai Health; [2]University of Toronto; [3]University Health Network.

Background/Purpose: HIV is frequently under-recognized in older individuals, particularly women, despite a growing proportion of new diagnoses occurring in those aged >50 years. Women living with HIV face unique, intersectional challenges due to aging, gender, and stigma. This scoping review aimed to explore their age-related experiences and challenges through an intersectional lens to inform supportive interventions.

Method: A systematic scoping review was conducted using the Arksey and O'Malley framework and guided by a Sex- and Gender-Based Analysis Plus (SGBA+) approach. Research questions were developed with input from community advisory stakeholders. A comprehensive search strategy targeted studies focusing on women aged ≥50 years living with HIV, emphasizing health and social experiences. Inclusion criteria required at least 50% of participants to meet these characteristics. Data extraction included study features, participant demographics, and findings. A stakeholder advisory committee reviewed and contextualized results.

Results: Twenty-one studies were included. Key themes identified were stigma, emotional resilience, social support networks, and health management strategies. Women navigated complex decisions around disclosing HIV status, while leveraging social networks and personal resilience to manage health. Gaps in research on intersectional factors influencing health outcomes were noted.

Discussion: Findings underscore the need for tailored interventions that address stigma, promote resilience, and enhance social support. Incorporating intersectional perspectives into research and care is critical to advancing equity. Women aged ≥50 years living with HIV experience unique, multifaceted challenges. Targeted, intersectional approaches are essential to ensuring equitable access to care and fostering resilience in this population.

A Scoping Review of Video Consultation Programs for Older Adults

Jean Triscott[1], David Archibald[1], Karen Leung[1], Peter George Tian[1], Cathy Lu[1].
[1]Division of Care of the Elderly, Department of Family Medicine, University of Alberta.

Background/Purpose: The Glenrose Rehabilitation Hospital (Edmonton, AB) has been providing video consultations remotely to patients in Fort McMurray for more than a decade. We wanted to scope the published literature for similar programs. This scoping review will summarize video consultation programs for older adults.

Method: We searched OVID Medline, CINAHL and EMBASE (up to November 5, 2024) for video consultations programs between physicians and older patients. Two independent reviewers screened the results in two phases: a title-abstract screen followed by a full-text screen. Data extraction was done by one reviewer and reviewed by another.

Results: 248 unique citations were identified. After screening, 3 publications were included. Two additional publications

were included from checking the reference lists. These 5 studies were published in 2015-2024 and were done in the USA, UK, Singapore, and France (2). The study settings differed. Alexander (2024, USA) described an oncologic program with video consultations to patients either at home or at a remote regional center. Chen (2022, Singapore) described an oncologic program with a combination of video consultations and in-person assessments. Another study (Joughin, 2021, UK) described a limited program wherein perioperative video consultations were provided by three geriatricians during the COVID-19 pandemic. Georgeton (2015, France) and Salles (2017, France) provided video consultations in nursing homes. The studies reported varying outcome variables including satisfaction, time spent, and barriers.

Discussion: Five publications described video consultations for older adults. These consultations involved teams of specialists, and various tests were performed with the assistance of telemedicine.

IADL Disability, Life Satisfaction, and Depressive Symptoms Among Chinese Middle-aged and Older Adults: The Moderating Role of Social Participation Trajectory

Man-Man Peng[1], Pengfei Wang[2].
[1]Department of Social Work, The Chinese University of Hong Kong, Shatin, NT, Hong Kong SAR; [2]Department of Health Sciences, University of York, York, UK.

Background/Purpose: Existing literature lacks longitudinal studies on the association between IADL disability and depressive symptoms among middle-aged and older adults in China, as well as the impact of life satisfaction and social participation on this association. This study aims to provide empirical evidence for the prevention and intervention of depressive symptoms in middle-aged and older adults, thereby improving their quality of life and well-being.

Method: This study used data from the China Health and Retirement Longitudinal Study (CHARLS) waves of 2015, 2018, and 2020, focusing on middle-aged and older adults aged 45 and above (N=8719). We employed a cross-lagged model to conduct a longitudinal mediation analysis, aiming to validate the longitudinal association and underlying mechanisms between Instrumental Activities of Daily Living (IADL) disability and depressive symptoms.

Results: The results revealed that: (1) IADL disability (wave 2015) positively predicted depressive symptoms (wave 2020), with life satisfaction (wave 2018) serving as a significant longitudinal mediator between the two; (2) Social participation trajectory (from wave 2015 to wave 2020) significantly moderated the longitudinal associations among IADL disability, life satisfaction, and depressive symptoms. A higher social participation trajectory reduced the risk of depressive symptoms caused by IADL disability through its influence on life satisfaction.

Discussion: Enhancing life satisfaction by promoting social participation among middle-aged and older adults could, therefore, serve as an effective strategy for preventing and treating depressive symptoms associated with IADL disability.

Developing Dementia Decoded: Acute Care Dementia Strategy at The Ottawa Hospital

Matthew A Sacheli[1], Jennifer Koop[2], Marice Prior[1], Courteney Munch[2], Nadine Sebahana[3], Meghan Kelly[3], Allen R Huang[4], Tammy Pulfer[1].
[1]Regional Geriatric Program of Eastern Ontario; [2]Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital; [3]The Ottawa Hospital; [4]Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital, University of Ottawa.

Background/Purpose: Dementia cases in Canada are expected to rise from 600,000 to over 1.7 million. People living with dementia (PLWD) face 65% higher hospitalization rates and worse outcomes, including longer Emergency Department and hospital stays and a higher risk of harm. To address these issues, the Regional Geriatric Program of Eastern Ontario (RGPEO) and The Ottawa Hospital (TOH) have developed Dementia Decoded a strategy for dementia care in acute care settings.

Method: The strategy was designed using mixed methods, including an environmental scan, literature review, interviews, surveys with staff, physicians, caregivers, and PLWD, and multidisciplinary focus groups with clinical and academic experts. This scoping work, including the review of the data, was reviewed by a representative group from geriatric medicine, geriatric psychiatry, and the RGPEO.

Results: Key outcomes from the scoping work and surveys highlighted the need for patient-centered care, early identification of PLWD in acute settings, and staff training. These insights shaped the three initial core pillars of the Dementia Decoded strategy: 1) Identification & Personhood: A dementia banner in electronic health records flags PLWD upon hospital encounter and links to key behavioural and care needs for the individual. 2) Interprofessional Care Plans: Personalized patient-centred care plans. 3) Education: A Dementia Champion Program to provide staff with tools and training.

Discussion: Dementia Decoded is one of Canada's first comprehensive acute care dementia strategies. Successful implementation will mean improved patient and caregiver experiences, better provider support, and greater health system efficiency. Future directions include expanding the strategy across Ontario and replicating it nationally.

Post-Stroke Osteoporosis Screening: A Scoping Review

Sydney Knight[1], Rachel Swance[2], Emma A Bateman[1], Kristin K Clemens[3], Alexandra Papaioannou[4], Jamie L Fleet[1].

[1]Department of Physical Medicine & Rehabilitation, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada; [2]School of Interdisciplinary Science, McMaster University, Hamilton, Ontario, Canada; [3]Department of Medicine, Division of Endocrinology, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada; [4]Department of Medicine, Division of Geriatrics and Rheumatology, McMaster University, Hamilton, Ontario, Canada.

Background/Purpose: Patients with stroke are infrequently screened for osteoporosis. There are no specific osteoporosis screening recommendations for patients post-stroke.

Aims: To explore the extent of evidence and map the current literature available for osteoporosis screening in the post-stroke population.

Method: This scoping review identified articles via Ovid Medline, Ovid Embase, and EBSCO CINAHL, published in English before May 2023, involving osteoporosis screening for adult patients after stroke. Studies with non-human participants, studies that were not peer-reviewed, or articles that were opinion pieces, comment letters, or reviews were excluded. Title and abstract screening as well as full text review and data extraction was performed by two reviewers. Analysis of the studies is descriptive and narrative.

Results: Eight articles were included (five published articles and three peer-reviewed conference abstracts). Three study designs were utilized, including one survey, four cross-sectional studies, and three cohort studies. Four studies aimed to investigate post-stroke osteoporosis screening rates, two looked at screening pathways for post-stroke osteoporosis, and two assessed novel osteoporosis screening tools. Reported screening rates for post-stroke osteoporosis were less than 10%. There were no post-stroke osteoporosis screening guidelines found.

Discussion: This scoping review emphasizes the need for osteoporosis screening guidelines and risk assessment tools specific to the post-stroke population.

Time Spent in Continence Related Tasks in Long Term Facility— A Prospective Real World Observational Study

Sadiksha Khanal[1], Saima Rajabali[1], Adrian Wagg[1].
[1]University of Alberta, Department of Geriatrics.

Background/Purpose: Urinary incontinence (UI) adversely affects nursing home resident's quality of life. Data on time spent in continence care shows discrepancies between times reported by staff versus simulation labs. Therefore, this study aimed to measure time spent by staff on continence care in long-term care.

Method: Time spent in continence related tasks (recorded by a stopwatch) for each of 5 resident dependency profiles was examined in a single nursing home. The dependency level G2 comprises mostly independent populations that can achieve full toileting but require occasional support whereas G6 is a care dependent population requiring full toileting assistance.

Results: The most time consuming day shift task was toileting assistance with pad/product change. The mean (SD) time (mins) for profiles G2-3 (less dependent) was 7'57 (5'32) and 10'28 (4'57) for G4-6 (more dependent). Pad/product check/change took the least amount of time during the day shift with mean (SD) time of 4 '7± 7'06 for profiles G2-3 and 2'19 ± 2'25 for G4-6. For night shifts, the mean (SD) time for toileting assistance with pad check/change was 2 '31 (0.09) for profiles G2-3 and 9' 14±4'23 for G4-6. The mean time for pad check/ change only was 4'25 ± 2'34 for profiles G4-6.

Discussion: Considerable time is spent in continence care but tasks are often intertwined with others, making time estimates difficult. The results of this study will allow assessment of potential efficiency gains in the workplace brought about by technological interventions to improve care delivery.

Empowering Clinicians: A Review of Educational Interventions for Tackling Polypharmacy and Deprescribing: A Literature Review

Samantha Yau[1], Sydney Eng[2], Thiru Yogaparan[1], Jenny Moloney[1], Anna Berall[1], Kiara Ramirez[1], Aliya Hirani[1].
[1]Baycrest; [2]University of Waterloo.

Background/Purpose: Polypharmacy is a global problem and increases the risk of adverse outcomes, which can be addressed by deprescribing - reducing or stopping medications that are no longer beneficial or may cause harm. Educational programs designed to overcome barriers to deprescribing among clinicians could improve patient-centered medication management. Our aim is to perform a literature review to evaluate the effectiveness of various educational interventions on reducing inappropriate medication use and prescribing in older adults.

Method: Data sources: Articles published between 2009 to 2024 indexed in MEDLINE and PubMed focused on educational interventions on polypharmacy or appropriate prescribing, for healthcare providers in long-term and subacute care settings. Our search identified 23 papers and 18 reviewed.

Results: Participants of the educational intervention were nurses, physicians, and/or pharmacists, (12/18); or students (6/18). Educational approaches included didactic teaching (8/18), case/problem-based learning (5/18), and a variety of educational approaches such as simulation, e-learning, gamification and academic detailing. Learning objectives included an overview of polypharmacy, deprescribing tools or strategies and drugs frequently related to adverse reactions in older people. Interventions improved clinicians' knowledge, confidence, and awareness, leading to reductions in potentially inappropriate medications and better medication adherence.

Discussion: Multiple educational approaches to address polypharmacy management and appropriate prescribing have

been studied. They vary in terms of their complexity, applicability and usability, and no "gold standard" is identified. The limitations of the polypharmacy interventions include biases from participant selection, incomplete data, lack of control over certain factors like patient outcomes and crossover between groups, and insufficient long-term follow-up or sustained coaching.

Characterizing the Prevalence of Limb-holding Physical Restraint Use for Older Adults at The Ottawa Hospital (TOH)

Seung Heyck (Alex) Lee[1], Marce Miron-Celis[2], Hannah Ramsay[3], Kylie McNeil[1], Shirley Huang[4], Miriam Thake[4].
[1]Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada; Ottawa Hospital Research Institute, Ottawa, Ontario, Canada; [2]Ottawa Hospital Research Institute, Ottawa, Ontario, Canada; [3]Department of Medicine, University of Toronto, Ontario, Canada; [4]Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada; Ottawa Hospital Research Institute, Ottawa, Ontario, Canada; Division of Geriatric Medicine, Department of Medicine, The Ottawa Hospital, Ontario, Canada.

Background/Purpose: Limb-holding restraints are used to reduce risk falls, prevent harmful behaviours, and increase treatment adherence despite no evidence suggesting their effectiveness. Older adults are at greater risk of being restrained and are likelier to suffer the negative effects of restraints. Despite these concerns, limb-holding restraints are widely used with no national or local systems in place to track their use. This lack of monitoring makes it difficult to trend or evaluate the effectiveness of interventions to reduce limb-holding restraint use.

Method: Electronic medical record (EMR) data for restraint orders was obtained from 2022–2023. This data was compared to limb-holding device orders annual ward-based prevalence data, and Safety Learning System (SLS) incidence reports.

Results: Comparison of the four data sources revealed significant discrepancies in prevalence rates. EMR data allows for real-time monitoring, but underestimates restraint prevalence due to inconsistent documentation. Ward-based prevalence data, though likely more accurate, is only available once a year and is resource-intensive to collect. Procurement data does not provide information regarding who the devices were ordered for or if/how/when they were used. SLS data provides detailed reports on concerns regarding restraint use but does not capture prevalence.

Discussion: Current monitoring systems for limb-holding restraint use prevalence are limited. It is challenging to monitor trends or the success of interventions to reduce the prevalence of restraint use for older adults at TOH. Further work is needed to establish real-time monitoring systems allowing implementation of restraint-reduction strategies that promote alignment with least restraint principles at TOH.

Impact of Bed Rest on the Gut and Oral Microbiome: Implications for Frailty

Monica Alvaro Fuss[1], Vanessa DeClercq[2], Susan Howlett[2], Joanna M. Blodgett[3], Olga Theou[4], Morgan G.I. Langille[2], Robert G. Beiko[1].
[1]Faculty of Computer Science, Dalhousie University; [2]Department of Pharmacology, Dalhousie University; [3]Institute of Epidemiology & Health Care, University College London; [4]School of Physiotherapy and Division of Geriatric Medicine, Dalhousie University.

Background/Purpose: The physiological effects of microgravity resemble those of aging and prolonged inactivity, and human-associated microorganisms are thought to contribute to resulting frailty increases. Thus, microgravity analogs such as 6º head-down tilt bedrest (HDBR) have emerged as promising models for studying frailty in humans. Here, we evaluate the effects of both inactivity and exercise on the gut and oral microbiomes of participants in The Canadian Ageing and Inactivity Study.

Method: 22 healthy participants aged 55-65 underwent 14 days of HDBR. Half performed a daily multi-modality exercise countermeasure. Participants recovered under supervision for seven days. Fecal (n=343) and salivary (n=344) samples were collected and analyzed using 16S rRNA gene sequencing. Frailty was assessed using a 36-item symptom-based frailty index.

Results: The gut microbiome of the control (inactivity) group showed reduced diversity during bedrest (p=0.018), along with shifts in 11 taxa, including decreased Akkermansia (p=5.76e-07), Lactobacillus (p=0.00143), and increased Bacteroides (p=1.85e-12). In the exercise group, changes were observed in 4 taxa, including increased Roseburia (p=0.00477). Only 2-3 taxa were altered in the oral microbiome of either group. Notably, oral microbiome profiles were more strongly associated with frailty (R^2=0.00442, p=0.036) than gut microbiome profiles (R^2=0.00038, p=0.419).

Discussion: Inactivity during HDBR was associated with gut microbiome changes previously linked to frailty in older adults. These alterations were absent in the exercise group, suggesting a protective effect of physical activity. The oral microbiome was also affected, and may serve as a more sensitive indicator of frailty than the gut microbiome.

The Plus45 Clinic: A Consultative Model of Care for Older Adults with Intellectual and Developmental Disabilities

Samuel Neumark[1], Jenna Mistry[1], Dasha Choitova[2], Angela Gonzales[2], Paula Green[2], Mark Lachmann[3].
[1]MD Program, Temerty Faculty of Medicine, University of Toronto; [2]Surrey Place; [3]Sinai Health.

Background/Purpose: Individuals living with Intellectual and Developmental Disabilities (IDD) are living longer in our

communities and require specialized services to address their unique aging health needs. This quality improvement project aims to assess the "Plus 45 Clinic" interprofessional service at Surrey Place in Toronto, Ontario, focusing on adults ≥45 years old with IDD, and supporting their families, caregivers and circles of care.

Method: We performed a retrospective chart review of all clients from January to December 2024. We extracted data on the quantity of referrals, assessments, service utilization, and individuals diagnosed with neurocognitive impairment, dementia, or mental health disorders. All data were anonymized for analysis and descriptive statistics were used to report the findings.

Results: In 2024, the Plus 45 Clinic accepted 89 referrals, performed 53 psychiatric assessments, and provided a combination of in-person, virtual, hybrid, and home consultation services. The average age was 59 (range 41-78), 51 (62%) male, 22 (27%) with dementia, 27 (33%) with Down syndrome, and 42 (51%) with a dual diagnosis (IDD and mental health).

Discussion: An interprofessional team comprised of a geriatric psychiatrist, clinical nurse specialist, registered behaviour analyst, and transitional services facilitator is important to address the physical and social determinants of health for this population as they begin their aging journey. There is a high demand for a model of care to address the unmet need for specialized health services for older adults with IDD. More health systems should adopt, invest, and advocate for clinical services to care for this vulnerable population.

A Structured Regional Approach to Building Capacity in SGS: Development and Adoption

Shaen Gingrich[1], Nicole Gallagher[2], Dana Corsi[2], Sara McEwen[2], Melanie Briscoe[2], Jo-Anne Clarke[2].
[1]North East Specialized Geriatric Centre; [2]North East Specialized Geriatric Centre, Health Sciences North.

Background/Purpose: Clinicians working in Specialized Geriatric Services (SGS) require expertise in geriatric assessment, interprofessional collaboration, and person-centered, goal-based care. In 2022, Ontario's North East Health Region received Alternate Level of Care (ALC) initiatives funding to expand services, resulting in extensive clinician hiring and onboarding. North East Specialized Geriatric Centre (NESGC) recognized the need and developed a standardized, structured regional approach to equip clinicians with the competencies to deliver high-quality geriatric care.

Method: Between October 2022 and December 2024, 72 clinicians were hired across the region. NESGC collaborated with clinicians and their teams to guide onboarding and create a structured approach tailored to individual, team, and organizational needs. Feedback was used to refine the approach.

Results: NESGC's iterative process and feedback finalized 5 key components: (1) self assessment, (2) development of foundational knowledge, skills, and attitudes, (3) shadowing and mentorship, (4) building support systems, (5) maintaining and advancing clinical competence. Of 72 newly-hired clinicians, 65 (90%) completed components 1 and 2 and 81% completed component 3. While components 4 and 5 are less concrete, there is evidence of their adoption through participation in local initiatives, regional SGS networks, and advanced training.

Discussion: By engaging clinicians in an iterative process, NESGC refined a structured regional approach to building capacity in SGS while allowing tailoring to meet local and individual needs. Broad adoption highlights the approach's success and suggests it might provide a valuable structure for other regions seeking to enhance onboarding. Further study is required.

Electronic Documentation of Goals of Care Designations among Alberta-based Geriatric Patients

Suzanne Aronyk[1], Peter Tian[1], Kimberley Higgins[1], Lesley Charles[1].
[1]University of Alberta.

Background/Purpose: Goals of Care Designations are important medical orders used to determine the appropriate level of medical intervention for patients in the event of life limiting illness. Canada has an aging population and individuals are living with higher levels of chronic illness and comorbidity. As patient autonomy increases, it has become increasingly important to have accurate and up to date documentation of a patient's medical wishes for life sustaining care. Our objective was to determine the frequency and characteristics of EMR-documented Goals of Care Designations.

Method: This was a retrospective chart review of 400 patients 65 years of age and over seen for outpatient Comprehensive Geriatric Assessment at the University of Alberta Hospital from July 1, 2022 - June 30, 2023. We extracted the frequency of Goals of Care Designation (GCD) orders determined by historical data available within selected patient charts, the setting of each order and the specialty of each provider completing the Goals of Care order.

Results: Only 49.3% (197/400) of patients had any documented GCD form completed on their EMR. Of the 356 completed GCD forms, 267 (75%) were completed in an inpatient setting; the majority of GCD forms were completed by a specialist in Internal Medicine (39.89%, n=142) or Family Medicine (37.64%, n=134).

Discussion: Our study revealed that less than half of the study patients had any GCD documentation in the provincial EMR. As accurate Goals of Care documentation is vital to patient care and autonomy, every opportunity should be taken by to complete this essential documentation.

Improving Frailty Measurement Using Electronic Health Care Data: A Scoping Review

Shara Fitzgerald[1], Geoffrey Anderson[2].
[1]Scarborough Health Network; [2]University of Toronto.

Background/Purpose: Early identification of patient frailty is important for population health planning. There is a growing interest in frailty identification through large healthcare databases. The Ontario Health Teams (OHTs) use the Johns Hopkins Adjusted Clinical Groups indicator to measure frailty, but it is unknown if this is the most effective tool. Machine learning (ML) algorithms are increasingly used to characterize meaningful patterns in large datasets, which may have an application to frailty identification. This project aimed to 1) identify validated clinical and ML methods of measuring frailty using healthcare databases and 2) recommend the most effective frailty indicator to the OHTs.

Method: A scoping review was conducted using PRISMA methodology. A systematic search was conducted in MEDLINE, EMBASE, and HEALTHSTAR. 3437 abstracts were identified. After title, abstract and full-text review, 87 articles were included.

Results: 93 frailty indicators were identified. Indicators were classified as indexes (45), ML models (28), phenotypes (5), or unspecified (13). Indicators used claims data (35), clinical databases (20), or electronic health records (45). 44.2% of indicators used ML methodology, 50% clinical and 5.7% both. The most common method of frailty indicator validation was area-under-the-curve (AUC) for mortality. In literature, the Johns Hopkins indicator has an AUC-mortality of 0.56. Sixteen frailty indicators had an AUC higher than 0.56, indicating better predictive value. There was no significant difference in predictive value for indicators using ML versus clinical methodologies (p=0.2518).

Discussion: This scoping review identified 16 frailty indicators for healthcare databases that may improve the current method of frailty identification by OHTs.

Seniors Outreach Program Sociodemographic Survey: A Quality Improvement Project

Sharon Hoosein[1], Lilibeth Jones- Lim[2], Florence Paat[2], Sarah Traynor[3], Chamaine Rodrigues[4], Bonnie Joanisse[3], Anna Trusz[3], Harvinder Dhillon[3], Telisha Lee[3], Mavis Knight[3], Kathleen Llamzon[3].
[1]Trillium Health Partners/ McMaster University/Regional Geriatric Program; [2]Trillium Health Partners, University of Toronto; [3]Trillium Health Partners; [4]Trillium Health Partners, Regional Geriatric Program.

Background/Purpose: We aimed to understand the sociodemographic characteristics of seniors accessing the Regional Geriatric Medical Outreach Program (RGMOP) at Trillium Health Partners (THP). Purpose is to identify any potential inequities in the current service mode in the community and also compare findings to an earlier project focused on seniors accessing the emergency department (ED).

Method: A standardized sociodemographic survey was mailed to patients seen by the RGMOP team members. Data was collected over a 4 month period using descriptive statistical analysis and trends were identified.

Results: Most patients identified as White (43%) with the most common language spoken after English being Arabic, Italian, South Asian languages and Tagalog. Most identified having a Disability/Illness identified as Physical Disabilities and Alzheimer's Disease/Dementia. Approximately 25% indicated their household income is below the current poverty line for Toronto, and 25% of respondents indicated they had difficulty paying for basic needs. We note a more diverse representation of patients when compared to the ED, similar in complexity, and similarly reported having low family income.

Discussion: The findings highlighted the need for exploring and linking culturally tailored community services to older adults from ethnic minority backgrounds to promote equitable access. Financial insecurity was also evident which necessitates the need to explore appropriate social services. Moreover, the findings revealed a high level of medical complexity that may be addressed through rigorous and systematic triaging approach. We leveraged insights gained from the sociodemographic survey to identify gaps and inequities then develop tailored strategies to better service the underserved communities.

Don't Forget About Oral Health, Oral Assessments for Older Adults Living with Frailty in Geriatric Care: A Scoping Review

Sophia Matarazzo[1], Patricia Hewston[2], Mark Lin[3], Esther Coker[4], Caroline Marr[5], Afeef Vehra[1], Alexandra Papaioannou[6].
[1]Geras Centre for Aging Research, Hamilton, ON, Canada; Department of Science, McMaster University, Hamilton, ON, Canada; [2]Geras Centre for Aging Research, Hamilton, ON, Canada; Department of Medicine, McMaster University, Hamilton, ON, Canada; [3]Department of Prosthodontics, Faculty of Dentistry, University of Toronto, Toronto, ON, Canada; [4]Geras Centre for Aging Research, Hamilton, ON, Canada; School of Nursing, McMaster University, Hamilton, ON, Canada; [5]Geras Centre for Aging Research, Hamilton, ON, Canada; [6]Geras Centre for Aging Research, Hamilton, ON, Canada; Department of Medicine, McMaster University, Hamilton, ON, Canada; Department of Health Research and Methods, McMaster University, Hamilton, ON, Canada.

Background/Purpose: Oral health has been described by the World Health Organization as a crucial yet often neglected area of healthy aging. For older adults living with frailty, poor oral health affects nutrition, social connections, and quality of life. Despite its significance, oral health is often overlooked in geriatric care, leaving treatable conditions unaddressed. This

scoping review aims to summarize oral health assessments available for non-dental healthcare professionals to detect oral health issues in older adults (65+) living with frailty.

Method: Using Arksey and O'Malley's framework, a primary search of COCHRANE, EBSCO, CINHAL, EMBASE, PubMed, SCOPUS, and MEDLINE was conducted. The inclusion criteria were (i) older adults (65+) living with frailty identified by formal tools and (ii) outcomes of oral health assessment. Data were synthesized to evaluate tools based on oral health domains, administration time, training requirements, and reliability for clinical use.

Results: A total of 16 oral health assessment tools were identified and categorized into four domains: oral health-related quality of life, swallowing and dry mouth, general oral health, and comprehensive assessments. Administration times ranged from 1 to 25 minutes, with six self-reported tools and ten examiner-rated tools. Seven tools required no formal training, making them highly accessible for non-dental professionals, while seven required minimal training and two required extensive training.

Discussion: This review presents a range of oral health assessments, enabling healthcare providers to select those best suited to their practice, facilitating referrals, and improving the health and quality of life of older adults with frailty.

What Works Best for Healthy Ageing? Evaluating the Implementation and Impact of NORC Supportive Service Programs (SSP) in Canada

Stephanie Hatzifilalithis[1], Rachel Savage[1], Vincent De Paul[2], Tai Huynh[3], Catherine Donnelly[2], Jay Shaw[4], Jennifer Shuldiner[5], Christine Sheppard[6], Kevin Brown[7], Mary Anne Denny-Lusk[8], Michael Hillmer[9], Patrick Feng[4], Shoshana Hahn-Goldberg[10], Kerry Kuluski[11], Noah Ivers[5], Paula Rochon[1].

[1]Women's Age Lab, Women's College Hospital; [2]Queens University; [3]UHN, NORC Innovation Centre; [4]University of Toronto; [5]Women's College Hospital; [6]Wellesley Institute; [7]Public Health Ontario; [8]Barrie Housing; [9]Ministry of Health/Ministry of Long-Term Care; [10]University Health Network, NORC innovation Centre; [11]Institute for Better Health, Trillium Health Partners.

Background/Purpose: Naturally occurring retirement communities (NORCs) are geographic areas that have naturally, over time, come to house a high concentration of older adults. Supportive service programs (SSPs) in NORCs have been shown to support healthy aging but are underutilized due to limited information on how to successfully implement and sustain these programs. Our objective is to address this gap by evaluating the implementation of NORC programs in two Canadian cities.

Method: In collaboration with University Health Network's NORC Innovation Centre and Barrie Housing, we are evaluating the implementation of three NORC SSPs of varying support intensities across ten sites in Toronto and Barrie. We are using a comparative case study design to explore in-depth how NORC models are implemented at diverse sites and factors influencing this process, guided by the Consolidated Framework for Implementation Research (CFIR).

Results: Our ten sites house almost 3000 people aged 65+, with almost 1/3 of that population being older women. We present early learnings from several of our evaluation sources such as an annually distributed resident wellness survey (n=197) and focus groups from program recipients (n=22). By evaluating one co-op, three condos, and six social housing sites we can investigate implementation process and its impact on older adults' health, well-being, and healthcare utilization as well as address effectiveness across the intersections of income, age, sex, and gender.

Discussion: NORC SSPs are proven interventions that can help many older adults age in place. Our research helps identify how to successfully implement and sustain these programs in equitable ways.

Piloting a Geriatric Rapid Access Clinic Targeting High-Risk Older Adults in the Emergency Department

Amine Kaab[1], Kristina Kokorelias[2], Lindy Romanovsky[3], Kristine Kim[3].

[1]Temerty Faculty of Medicine, University of Toronto; [2]Division of Geriatric Medicine, Department of Medicine, Sinai Health System, Division of Geriatric Medicine, Department of Medicine, University Health Network, Department of Occupational Science & Occupational Therapy, Temerty Faculty of Medicine, University of Toronto, Rehabilitation Sciences Institute, Temerty Faculty of Medicine, University of Toronto; [3]Division of Geriatric Medicine, Department of Medicine, Sinai Health System, Division of Geriatric Medicine, Department of Medicine, University Health Network, Department of Geriatric Medicine, Temerty Faculty of Medicine, University of Toronto.

Background/Purpose: Older adults are disproportionately frequent users of the emergency department (ED), with increased risks of functional decline and hospital admission. To provide more proactive geriatric care and prevent readmission, Sinai Health piloted the Geriatric Rapid Access Clinic (Geri-RAC), providing timely geriatrician-led assessments for high-risk older adults post-ED visit. This study evaluates the Geri-RAC's pilot performance to guide service improvements.

Method: A retrospective chart review was conducted for patients attending the Geri-RAC from January 2023 to July 2024. Descriptive statistics outlined patient demographics and Geri-RAC performance outcomes.

Results: During the pilot, 31 patients (mean age 82.1 years, 80.6% women) attended the Geri-RAC, of which 51.6% lived alone and 41.9% required home supports. Of 58 ED referrals, 31 (53.4%) attended, resulting in a 46.6% no-show rate. All patients received comprehensive geriatric assessments and

medication reviews, 74.2% underwent cognitive testing, and patients averaged 2.1 community service referrals. Follow-up occurred for 58.1% of patients. The average time from ED referral to Geri-RAC visit was 9.7 days, and only 4 patients (12.9%) revisited the ED within 30 days.

Discussion: The pilot results reveal a significant no-show rate, emphasizing the need to investigate appointment access challenges including scheduling, transportation, patient support needs, and cognitive status. Compared to the 1-5 month institutional wait time for a geriatrician, the Geri-RAC provides considerably faster access to comprehensive geriatric assessments, cognitive testing, community and specialist referrals, and follow-ups. Continued evaluation will be critical for optimizing the Geri-RAC and refining referral pathways to better meet patient needs.

Ontario Delirium Quality Standard Implementation: A Multicomponent Interdisciplinary Quality Improvement (QI) Project: 4AT Screening Tool Implementation

Thirumagal Yogaparan[1], Jenny Moloney[1], Samantha Yau[1], Stephanie Grenier[1], Shelley Veinish[1].
[1]*Baycrest.*

Background/Purpose: We conducted an interdisciplinary, multicomponent QI project to improve the prevention, identification, and management of delirium on two geriatric rehabilitation units at Baycrest Hospital.

Method: In phase one, we conducted a baseline assessment through retrospective chart reviews, surveys, and process mapping. The CAM showed low delirium detection rates despite higher prevalence in chart reviews. Due to CAM's low sensitivity and extensive training requirements, the 4AT screening tool was introduced in April 2024 Interprofessional team received education on delirium and the 4AT tool. Nurses shifted from conducting daily CAM screenings to daily 4AT screenings for all patients. The study monitored the completion of 4AT screenings within 24 hours of admission and tracked the number of positive screening results. A coordinated care plan was developed to ensure prompt physician notification for patients with positive screenings. Post-launch Plan-Do-Study-Act (PDSA) cycles were implemented to gather comprehensive feedback from the team.

Results: The patients' average age was 85 years, with a range of 55–103 years. Following the transition from the CAM to the 4AT screening tool on the High Tolerance Rehabilitation Unit, the screening rate within 24 hours of admission increased from 74% to 83%. The overall percentage of positive screenings rose nearly nine fold, from 0.11% with the CAM to 0.98% with the 4AT between April 2024 and October 2024.

Discussion: The introduction of the 4AT screening tool, supported by education, implementation of a coordinated care plan, significantly improved delirium screening rates within 24 hours of admission, as well as the detection and diagnosis of delirium.

Frailty-Related Inflammatory Markers Modified by Sex in a Bed Rest Study

Maddison L Hodgins[1,2], Judith Godin[2], Joanna M Blodgett[5], Scott A Grandy[1,3], Kenneth Rockwood[2], Olga Theou[2,4], Susan E Howlett[1,2].
[1]*Department of Pharmacology;* [2]*Department of Medicine (Geriatric Medicine);* [3]*School of Health and Human Performance;* [4]*School of Physiotherapy, Dalhousie University, NS, Canada;* [5]*Institute of Sport Exercise & Health, Division of Surgery & Interventional Science, University College London, UK.*

Background/Purpose: Prolonged bedrest can induce physiological stress. This may exacerbate inflammation and promote frailty, especially in older adults. We explored whether Head-Down Tilt (HDT) bedrest with or without exercise altered inflammatory markers implicated in frailty.

Method: Males and females were subjected to HDT bedrest (2-weeks). Half were randomly assigned to a high-intensity interval/aerobic/strength training exercise intervention (60 minutes/day; Control: n=4 males, 5 females; Exercise n=5 males, 6 females). Frailty index scores and serum inflammatory cytokines were regularly measured during bedrest (days 0,1,3,7,14), and recovery (days 0,4,32). Data were analyzed with linear mixed models.

Results: Proinflammatory markers (interleukin (IL)-6, IL-8) increased during bedrest but were higher in males than females (IL-6: β=8.87, IL-8: β=12.93; $p<0.01$). IL-8 declined during recovery in all, although IL-8 and IL-6 remained higher in males (IL-6: β=9.32, IL-8: β=2.85, $p<0.01$) throughout the study. Thejh anti-inflammatory cytokine IL-10 was higher in males than females during bedrest. Il-10 declined throughout recovery but remained highest in males. During bedrest, proinflammatory cytokines (IL-1β, IL-12) increased as frailty increased (IL- β: β=0.01, IL-12: β=0.02, $p<0.05$) whereas monocyte chemoattractant protein-1 declined with frailty (β =-20.54, $p<0.05$). The anti-inflammatory protein IL-1ra (blocks IL-1), increased with frailty throughout bedrest in all, especially those who exercised (β=3.15, $p<0.01$).

Discussion: Inflammatory markers increased during bedrest, declined during recovery and were higher in males than females. Some inflammatory markers increased in parallel with frailty during bedrest. As exercise increased IL-1ra levels, this intervention may help reduce inflammation in older adults exposed to prolonged bedrest.

Health Outcomes of Older Adults in Ontario Long-term Care Homes Following Hospitalization for Hip Fracture Surgery

Tiffany Yu[1], Nicholas Yee[2], Maya Murmann[3], Benoît Robert[4], David Kirkwood[5], Richard Perez[5], Amy Hsu[3].
[1]*University of Ottawa, Faculty of Medicine;* [2]*University of Toronto, Department of Surgery, Division of Orthopaedic*

Surgery; [3]Bruyère Health Research Institute; [4]University of Ottawa, Department of Family Medicine, 5ICES McMaster.

Background/Purpose: Hip fractures are among the most common and debilitating conditions in the elderly population, particularly for those living in long-term care (LTC) homes. Fractures can lead to reduced quality of life and earlier onset of mortality. Surgical procedures used to manage these fractures are associated with multiple complications. As a result, older adults in LTC and their families often confront the difficult decision of whether to undergo surgery. In this study, we compare outcomes of hospitalized older adults in Ontario LTC homes that did or did not undergo hip fracture surgery.

Method: Data on older adults was identified through the Institute for Clinical Evaluative Sciences (ICES) from 2015 to 2019. Through surgical codes, we further differentiated those who received a surgical intervention from those who did not. Baseline characteristics and post-discharge outcomes (including mortality) were also retrieved from ICES.

Results: Among 5,279 older adults meeting inclusion criteria (mean age: 87.01 years, 74.2% female), 4,547 (86.1%) underwent surgery. Compared to those surgically managed, non-surgically managed participants reported more cases of osteoporosis, hypertension, renal failure and greater functional impairment—indicating greater frailty and multimorbidity. Six months post-discharge, older adults who were surgically managed reported fewer deaths in the hospital, were less likely to experience frequent or severe pain, and remained more functionally independent. However, they were also more likely to be physically restrained.

Discussion: Hip fracture surgery was associated with lower mortality. However, differences in outcomes between groups may be associated with baseline characteristic differences. Additional regression modelling analysis is required to account for these differences.

One Call, One Navigator, One Team: Redefining Interdisciplinary Approaches in an Ontario Homecare Organization

Titus Chan[1], Doris Amankwah[1], Trevor Heer[1], Glenda Providence[1], Matthew Wong[1].
[1]VHA Home Healthcare.

Background/Purpose: Ontario's homecare system faces structural challenges that contribute to siloed care, hindering coordination for clients accessing multiple services. VHA Home Healthcare responded to this sector-wide issue with two objectives: (1) implement and evaluate the feasibility of a novel integrated model for publicly-funded homecare within the organization, and (2) investigate its impact on client and provider experiences regarding interdisciplinary care.

Method: Through a multi-stage participatory process engaging client partners, clinical providers, administrators, and leaders, the co-designed VHA One Team model yielded four transformative components: (1) a care navigator, (2) integrated supervision, (3) a centralized phoneline, and (4) an evidence-informed interprofessional framework. Piloted over six months in Toronto during 2024, a theory-based evaluation was undertaken with an exploratory, convergent-parallel design anchored in the Quintuple Aim for Healthcare Improvement framework. Data sources included key performance metrics, surveys, interviews, and focus groups.

Results: The One Team model supported 487 clients (Mage = 80), with 52.6% receiving multidisciplinary services at VHA. Personal Support Workers demonstrated the highest acceptability and adoption of changes, alongside meaningful service expansion to incorporate interdisciplinary components. Integration by Allied Health and Nursing teams was less consistent, with implementation barriers influenced by public funding structures. Clients reported moderately high satisfaction; however, lower participation among those accessing multiple services underscored the need for targeted changes enhancing engagement and equity in care delivery.

Discussion: Integrated homecare models show promise in enhancing interdisciplinary coordination while uncovering challenges shaped by Ontario's public funding structures. Our insights inform the advancement of innovative, co-designed solutions for homecare organizations pursuing integration sector-wide.

Association Between Subcutaneous Fat Thickness Measured by Point-of-Care Ultrasound and Fat Percentages Measured by Dual-energy X-Ray Absorptiometry Percentages in Older Adults

Uyanga Ganbat[1], Boris Feldman[1], Shane Arishenkoff[2], Graydon Meneilly[3], Jonathan Little[1], Teresa Liu-Ambrose[1], Kenneth Madden[1].
[1]UBC; [2]UBC, VCH; [3]UBC/VCH.

Background/Purpose: Point-of-care ultrasound (POCUS) has emerged as a promising tool for assessing skeletal muscle mass through muscle thickness measurement. Additionally, POCUS can measure subcutaneous fat thickness (SFT), offering potential insights into body fat composition. We hypothesized that SFT measured via POCUS would correlate strongly with body fat percentage as assessed by dual-energy X-ray absorptiometry (DXA).

Method: This study included 121 participants (80 females and 41 males). Subcutaneous fat thickness was measured using B-mode ultrasound in four sites (quadriceps, gastrocnemius, biceps, and triceps). DXA was used to obtain total body, arm, leg, and trunk fat percentages.

Results: The mean participant age was 73.87 ± 6.36. Significant sex-based differences were observed in weight, height, waist, biceps, mean grip, quadriceps, gastrocnemius, triceps SFTs, and DXA-measured arm, leg, trunk, and total fat percentages. The strongest correlation between SFT and fat

percentage was observed between quadriceps SFT and mean leg fat percentage (R^2=0.76, p<0.001) and between quadriceps SFT and total body fat percentage (R^2=0.70, p<0.001). In univariate regression analysis, each 1-mm increase in quadriceps SFT explained a 2% increase in leg fat percentage (R^2=0.57, p<0.001).

Discussion: Our findings demonstrate a strong correlation between SFT measured by POCUS and DXA-measured body fat percentages. Among all SFT measurement sites, the quadriceps muscle SFT exhibited the strongest association with total body fat percentage. While further research is warranted, these results suggest that POCUS-derived SFT could serve as a reliable, non-invasive method for estimating body fat percentage.

Promoting Equity, Diversity, and Inclusion in Geriatric Healthcare Education: A Scoping Review Protocol

Vicky Chau[1], Kristina Kokorelias[2], Sachindri Wijekoon[3], Hardeep Singh[4], Maurita Harris[5].
[1]Mount Sinai Hospital, University of Toronto; [2]Mount Sinai Hospital; [3]University of Western Ontario; [4]University of Toronto; [5]Wilfrid Laurier University.

Background/Purpose: The integration of Equity, Diversity, and Inclusion (EDI) in geriatric healthcare education is essential to address the needs of an increasingly diverse aging population. This scoping review explores Equity, Diversity, and Inclusion (EDI) initiatives within geriatric healthcare professional education, aiming to understand strategies, outcomes, and challenges.

Method: This scoping review was conducted following the guidance of the Joanna Briggs Institute (JBI). A comprehensive search was conducted on May 11, 2024, using multiple databases (e.g., MEDLINE, PubMed, Embase, CINAHL) and grey literature sources, with guidance from a health librarian and adherence to the PRESS guideline statement. Articles were screened in duplicate.

Results: Eight articles met inclusion criteria, predominantly utilizing qualitative and mixed-methods designs. Initiatives ranged from active learning to online simulations, targeting physicians and allied healthcare providers. Participants generally reported high satisfaction and improved attitudes towards diversity and inclusion post-training. Challenges such as resource constraints and curriculum updates were noted. Multidisciplinary training and technological advancements emerged as key strategies, alongside recommendations for enhanced resource allocation and inclusivity in content and faculty.

Discussion: This scoping review will provide valuable insights into effective EDI strategies in geriatric healthcare education, helping to identify gaps in training, challenges, and opportunities for improvement.

Conclusion: Despite limitations such as potential language restrictions, this review will offer a comprehensive overview of current practices, contributing to evidence-based strategies for enhancing EDI in geriatric healthcare education and improving care for older adults from diverse backgrounds.

Quality of Life, Prevalence and Risk Factors of Urinary Incontinence Among Saudi Elderly Population

Waad Binafif[1], Bappa Adamu[2].
[1]Department of Geriatric Medicine, University of Toronto; [2]Department of Internal Medicine, University of Bisha, Kingdom of Saudi Arabia.

Background/Purpose: Urinary incontinence (UI) is a common health problem especially in geriatric populations. In Saudi Arabia, the reported prevalence ranges between 6.4-9.0%. We aimed to determine the prevalence of UI among Saudi elderly patients, associated risk factors, and its impact on their quality of life.

Method: A cross-sectional study using a pre-tested, interviewer administered questionnaire on elderly patients attending OPD clinic in our hospital. We excluded patients who underwent urological or gynecological surgery within the previous three months of data collection. The Arabic version of the international consultation incontinence questionnaire short-form (ICIQ-SF) was used to assess the prevalence of urinary incontinence and its impact on quality of life. Data analysis was performed utilizing the Statistical Package for Social Sciences (SPSS) software-version 28.

Results: A total of 203 elderly persons comprising 133 males and 70 females were included. The prevalence of UI was 22.2%. Multivariate logistic regression analysis revealed female gender, benign hypertrophy of the prostate and bronchial asthma were associated with statistically significant risk of UI. Severe interference of UI with everyday life was mentioned by 40% of the participants.

Discussion: This study revealed a much higher prevalence of UI compared to previous studies from Saudi Arabia. This maybe because of known risk factors in the population such as BPH and bronchial asthma. A potential explanation could be the aging Saudi population.

Conclusion: Urinary incontinence in elderly Saudi population is 22.2%, which is much higher than previously reported, and has negative impact on the quality of life in those affected.

Assessing the Veterans' Well-Being Surveillance Framework: Insights from the Canadian Longitudinal Study on Aging

William Van Veen[1], André Lauzon[2], Nicolas Laham[3], Gray Gaudett[4], Sara Rodrigues[5], Fardous Hosseiny[5], Stefania Maggi[3].

[1]Canadian Armed Forces; Atlas Institute for Veterans and Families; Carleton University; [2]Atlas Institute for Veterans and Families; Acadia University; [3]Carleton University; [4]Atlas Institute for Veterans and Families; Carleton University; [5]Atlas Institute for Veterans and Families; University of Ottawa; Institute of Mental Health Research at The Royal Hospital.

Background/Purpose: Well-being is a multidimensional construct. Despite comprehensive research, few studies have validated well-being frameworks longitudinally, especially regarding aging Veterans. The present study assesses constituent domains of well-being within Veterans Affairs Canada's (VAC) Well-Being Surveillance Framework and compares these longitudinally between Veterans and non-Veterans. By evaluating key indicators of well-being, this study provides insights that can guide evidence-based support services for Veterans and their families.

Method: The sample consisted of 38,502 aging Canadians who participated in the Canadian Longitudinal Study on Aging (CLSA). Structural equation modelling was extended through multi-group confirmatory factor analysis assessing life satisfaction and social integration among Veterans and non-Veterans via a cross-lagged panel model. Well-being domains encompassing social integration and purpose were modelled to assess their predictive validity in relation to depression.

Results: These latent constructs modelled effectively across time. Interestingly, while this model applied invariantly between female and male Veterans, when Veterans were compared to their non-Veteran counterparts of the same sex, the model applied differently.

Discussion: This study represents an initial step in exploring the utility of the VAC domains to examine older Veterans' well-being, and suggests that Canadian Veteran well-being is expressed differently, compared to non-Veterans. The study provides a template for researchers interested in assessing latent constructs over time. Findings demonstrate that acknowledging the need to distinguish Veterans from non-Veterans in the application of interventions, especially regarding social integration, purpose and depression as they diverge significantly from non-Veterans, is critical to tailoring policies and programs to support our Veterans.

Implementation of Therapeutic Drug Monitoring and Pharmacogenomics in Older Adults as a Model of Care: A Scoping Review

Kassandra Lemmon[1], Yang Qing Hu[2], Cindy Woodland[3], Tony Antoniou[3], Alexander Gola[4], Carolyn Tan[3], Jocelyn Tan[3], Jennifer Tung[5], Jack Bodkin[5], Howard An[3], Joanne Man-Wai Ho[6].
[1]GeriMedrisk, Schlegel-UW Research Institute for Aging; [2]University of Toronto, GeriMedRisk; [3]University of Toronto; [4]McMaster University; [5]GeriMedRisk; [6]GeriMedrisk, McMaster University, Schlegel-UW Research Institute for Aging.

Background/Purpose: The risk of adverse drug events (ADEs) due to aberrant drug levels is increased among older adults (≥60 years) due to pharmacologic changes with aging, and drug-drug or drug-disease interactions. Genetic differences may also affect an individual's response to medications and drug levels. Therapeutic drug monitoring (TDM) and pharmacogenomic (PGx) testing may help mitigate risks, however, currently neither are routinely used for older adults. This scoping review aims to map the existing literature to determine the impact, facilitators, and barriers of implementing TDM and/or PGx into routine clinical care of older patients.

Method: Selection criteria were age 60 or greater and use of TDM and/or PGx. The outcomes evaluated include patient-related factors, clinician-related factors, and health system-related factors. Privacy, scope, consent, and other facilitators or barriers to implementation were also examined. A comprehensive search of eight scientific databases and grey literature sources revealed 10,341 relevant papers. Title and abstract screening and full-text screening were performed, requiring a consensus between two independent reviewers. Of the screened articles, 35 qualified for and had data extraction performed (INPLASY2024110042).

Results: Facilitators to delivering TDM/PGx include participation of pharmacists, and positive patient and clinician attitudes. Barriers to implementation include gaps in clinician knowledge, lack of insurance coverage, and privacy concerns. Cost-effectiveness is debated, as 20% of papers reviewed indicate positive results and 17% have mixed or negative results.

Discussion: Future work should address the barriers to implementation and aim to incorporate routine use of TDM and PGx in older patients to decrease ADEs.

Clinical Profile of Heart Failure in Geriatric Patients in a Tertiary Cardiac Hospital of Bangladesh

Yesmin Mahbuba[1], Lutfun Nahar Nizhu[2].
[1]Sunnybrook Health Science Centre; [2]Square Hospital, Bangladesh.

Background/Purpose: Geriatric group of patients are the most vulnerable for compromised healthcare and heart failure is common in this age group. The objective of this study is to identify the clinical profile of heart failure in geriatric group of patients.

Method: This study included 100 hospitalized geriatric patients presenting with clinical features of heart failure in National Institute of Cardiovascular Diseases (NICVD) over one-month period. This was a single center, cross-sectional study.

Results: In total 100 patients were included in the study with a mean age of 77 years. Among them, 59% were female and 41% were male. The most common comorbidities were hypertension (40%), Ischaemic heart disease (36%), Atrial fibrillation (11%), Cardiomyopathy (7%) valvular heart disease (6%). Common cardiorespiratory symptoms included effort intolerance (38%),

dyspnea (14%), pedal oedema (17%), cough (14%), chest pain (11%), palpitation (6%). Regarding left ventricular ejection fraction (LVEF), heart failure (HF) was classified into the following categories: (1) HF with reduced EF (HFrEF) - 19%; (2) HF with improved EF (HFmpEF) - 13% and HF with mildly reduced EF (HFmrEF) - 22% and HF with preserved EF (HFpEF) - 46%. About 23% of the study population had Iron deficiency anemia which described that anaemia is a contributing factor in geriatric heart failure in our population. About one third patient had associated renal failure (AKI/CKD).

Discussion: A significant geriatric population has unrecognized heart failure (HFpEF). Our study findings will help better management of acute and chronic heart failure and preventive strategies as correction of anemia.

The Association Between Poor Social Health, Polypharmacy and Potentially High-Risk Medication Use

Zain Pasat[1], Julia Gilmartin-Thomas[2], Rosanne Freak-Poli[3], Alexandra Papaioannou[4], Jonathan Broder[5], Michael Ernst[6], John McNeil[5], Gustavo Duque[7], Justin Lee[8].
[1]McMaster University, Hamilton, Canada; [2]La Trobe University, Melbourne, Australia; [3]Monash University, Melbourne, Australia; [4]GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada; Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Canada; [5]Monash University; Melbourne, Australia; [6]University of Iowa, Iowa City, United States of America; [7]McGill University, Montreal, Canada; [8]Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Canada; Centre for Integrated Care, St. Joseph's Health System, Hamilton, Canada; GERAS Centre for Aging Research, Hamilton Health Sciences, Hamilton, Canada.

Background/Purpose: Poor social health (loneliness, social isolation and/or low social support) is associated with physical and psychological symptoms, such as pain, insomnia, anxiety, and depression. These symptoms may lead to prescription of multiple high-risk medications rather than social interventions that may address their underlying causes. We sought to evaluate the relationship between poor social health and polypharmacy and/or high-risk medication use.

Method: We conducted a secondary analysis of 16,439 older adults in the ASPREE Longitudinal Study of Older Persons (ALSOP). We used logistic regression to test whether loneliness, social isolation or lack of social support (individually and as a composite measure) were associated with polypharmacy and/or potentially high-risk medication use (i.e. opioids, sedative/hypnotics, and antidepressants).

Results: We identified 1259 older adults with poor social health. Polypharmacy was associated with loneliness (OR 1.46, 1.18-1.80, $p<0.001$) and low social support (OR, 1.13-1.67, $p=0.002$), but not social isolation. Poor social health (as a composite measure) was not significantly associated with polypharmacy. Poor social health was associated with sedative-hypnotic (OR 1.47, 1.20-1.78, $p<0.001$), opioid (OR 1.98, 1.41-2.72, $p<0.001$) and antidepressant use (OR 1.79, 1.33-2.21, $p<0.001$), but thresholds for statistical significance were not met in analyses adjusted for age, sex, frailty, co-morbidity and sociodemographic risk factors.

Discussion: Loneliness and low social support are associated with polypharmacy and they are important risk factors to consider when trying to deprescribe and optimize the medication use of older adults. Larger studies are needed to better understand the impact of poor social health on the prescription of many potentially high-risk medications.