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Objective: Health disparities between communities with greater and lesser advantages are a global concern. In the USA, self-identified race as African American (AA) is consistently associated with mild cognitive impairment (MCI) and dementia, compared to Americans of European descent. In a prospective population-based study, we sought to confirm this association and investigate potential explanatory factors.

Methods: The Monongahela-Youghiogheny Healthy Aging Team (MYHAT) and Seniors Project 15104 (SP15104) studies recruited adults aged 65+ years from a group of small towns of lower socioeconomic status in the US. MYHAT recruited by age-stratified random sampling from the voter registration list for all towns; SP15104 recruited by intensive community engagement from three towns with populations that are 60% AA. Based on the Clinical Dementia Rating (CDR), MCI was defined as CDR=0.5 and dementia as CDR > 1. Using Cox proportional hazard models, we modeled time to incident CDR > 0.5 from baseline as a function of race (AA vs. all other), other demographics, and several other covariates at baseline.

Results: The sample of 2120 individuals was 8% AA, and 62% female, with median age of 73y, and median educational level of partial college. During follow up of up to 14.5 years, 499 participants developed new-onset MCI/dementia (CDR >0.5). Cox models revealed that being AA was significantly associated with incident CDR > 0.5 (HR=1.45. 95% CI:1.01,2.10). Inclusion of age, sex, and education in the model increased the HR for race to 1.63 (1.1, 2.3). Adding number of regularly taken prescription drugs (reflecting overall morbidity), depression symptoms, preceding year alcohol consumption, and number of visits to emergency or urgent care together reduced the HR to 1.4 (0.96, 2.0), no longer statistically significant

Conclusions: In this population-based cohort study, self-identified African Americans had an about 40% elevated risk of developing MCI/dementia. Adjusting for demographics, the significant association between race and incident MCI/dementia was attenuated by variables reflecting depression, greater general morbidity, and lesser access to regular health services. These variables possibly reflect downstream effects of historic discrimination, but couldstill be modifiable risk factors for MCI/dementia. Addressing them could potentially mitigate ethno-racial disparities in cognitive impairment.

FC10: Telehealth for Older Adults: Developing telehealth competencies to ensure access, quality and equity across the lifespan

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Background: Telehealth has been an important method of health care delivery during the pandemic, particularly for older adults who have been more vulnerable to the physical and psychosocial impacts of the pandemic and associated isolation. Older adults have specific medical and mental health care needs that would benefit from having access to geriatric speciality services, however these services may be difficult to access especially for those living in rural areas. Though the use of technology and telehealth has greatly expanded during the pandemic,

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many health systems and clinicians lack the necessary knowledge, skills and attitudes to fully integrate technology in the health care of older adults. General telehealth competencies are available to guide educators, however, competencies to address the unique needs of older adults have yet to be developed.

Objectives: This literature review was conducted to evaluate what approaches are needed for clinicians to gain skills and knowledge in order to competently deliver telehealth services to older adults.

Methods: The review was completed using the six-stage scoping review process in line with the PRISMA checklist in PubMed/Medline and other databases from years 2000 to 2023 based on concept areas of (I) education/competencies, (II) telehealth delivery and (III) older adults.

Results: From a total of 813 articles, the authors found 88 eligible for full text review and 16 papers sufficiency relevant to the search criteria. Some evidence exists for telehealth competencies specifically for clinicians caring for older adults. Themes that emerged include the role of interprofessional and experiential learning, telepresence, technology training and support, and adaptations for older adults. Education of clinicians and trainees increased knowledge of its usefulness and improved attitudes related to acceptance and utilization. Training rather than ad hoc exposure to telehealth technology was emphasized. Clinician/student-provided training improved access and acceptance to telehealth in older adults. Suggested adaptations for older patients included the involvement of caregivers in the visit, especially for patients with cognitive impairment.

Conclusions: It appears that training – more than ad hoc experience – for clinicians and trainees increases knowledge, skills and attitudes toward telehealth for the care of older adults. Additional research is needed to define training interventions, cross-sectional versus longitudinal approaches and specify competencies (i.e., skills) and optimal learning methods.

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FC11: Guided low-intensity behavioural activation intervention delivery preferences among people with dementia, informal caregivers, and professional stakeholders: a qualitative study (the INVOLVERA Study)

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