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A higher percentage of Veterans in rural areas are older, have multiple chronic conditions and select the VA for healthcare. To address the needs of rural older Veterans with complex needs, GRECC Connect hubs use case finding approaches combined with regular outreach and education to VA community-based outpatient clinic (CBOC) providers serving rural Veterans and caregivers. Alignment of GRECC Connect services with needs of providers and patients promotes establishment of therapeutic alliances in caring for medically complex older Veterans. After identifying high risk, high need patients, hubs use the following strategies to increase access to geriatric specialty care through telehealth modalities: 1) Co-management of patients through e-consultation and telehuddles (GRECC Connect interprofessional geriatric specialty care teams extend support to CBOC providers); 2) Clinical video telehealth to CBOCs and Video on Demand to Veteran homes (to reduce travel burden); and, 3) Tele-group visits (especially for behavioral health and caregiver support).

SPREADING TELEHEALTH FOR OLDER ADULTS IN RURAL AREAS THROUGH NETWORK OF GERIATRIC INTERPROFESSIONAL TEAMS

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Older adults living in rural areas have limited access to geriatrics interprofessional team care. In the Veteran healthcare system, geriatric teams such as geriatricians, nursing professionals, social workers, pharmacists and psychologists, located in urban areas link up with rural clinics to provide geriatric consultation remotely through clinical video telehealth and other means in the project GRECC Connect. Since its inception in 2014, the service has now grown to 16 geriatric teams offering consultation to over 100 clinic sites serving older rural Veterans. GRECC Connect delivered over 2,000 consultations in 2019, meeting complex care needs by identifying and linking geriatric services and management to patients with geriatric syndromes. The network of established geriatric teams, local champions and a shared Electronic Health Record facilitated the spread, while ongoing effort to build and maintain relationships between consultants and local rural provider teams and other community based services are important for ongoing success.

TELEHEALTH COMPETENCIES FOR INTERPROFESSIONAL TEAMS CARING FOR OLDER ADULTS AND CARE PARTNERS

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Providing interprofessional geriatric care via telehealth is a unique clinical skillset that differs from providing face-to-face care. The lack of clear guidance on telehealth best practices for providing care to older adults and their care partners has created a systems-based practice educational gap. For several years, GRECC Connect has provided interprofessional telehealth visits to older adults, frequently training interprofessional learners in the process. Using our interprofessional telehealth expertise, the GRECC Connect Education Workgroup created telehealth competencies for the delivery of care to older adults and care partners for interprofessional learners. Competencies incorporate key telehealth, interprofessional and geriatric domains, and were informed by diverse stakeholders within the Veterans Health Administration. During this symposium, comments will be solicited from attendees. Once finalized, these competencies will drive the development of robust curricula and evaluation measures aimed at training the next generation of interprofessional providers to expertly care for older adults via telehealth.

MEDICAL STUDENT'S PERCEPTION OF DEMENTIA ASSESSMENT AND MANAGEMENT AMONG RURAL VETERANS

Prasad Padala,[1] Jessica Stovall,[2] Matthew Kern,[2] Jeremy Curtis,[2] Eugenia Boozer,[2] Shelly Lensing,[3] and Kalpana Padala,[2] *1. Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, United States, 2. Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas, United States, 3. University of Arkansas for Medical Sciences, Little Rock, Arkansas, United States*

Background: Rural Veterans rely on their caregivers, case managers and primary care providers for dementia management. Providers of such patients need to work closely with caregivers, know the local dementia resources and be comfortable with the multiple facets of dementia assessment and management. Unfortunately, medical students are not particularly well trained in these aspects and huge knowledge

gaps exist. The goal was to study the impact of a multicomponent, experiential, brief curriculum on attitudes of dementia care. Methods: 108 medical students participated in a curriculum including didactics, clinical, and team-based learning followed by pre-post assessments. Results: Student's perception of their ability to assess multiple facets of dementia such as behaviors, caregiver burden, and cognition improved significantly (p<0.001). Students' perception of the role of social worker improved significantly (p=0.002). Conclusion: An interdisciplinary curriculum, improved medical students' perception of their ability to assess for dementia in a cohort of predominantly rural Veterans.

SESSION 7220 (SYMPOSIUM)

SENSORY LOSS AND THE HEALTHCARE SYSTEM: OUTCOMES AND NAVIGATION

Chair: Nicholas Reed
Discussant: Charlotte Yeh

Communication is fundamental to patient-centered care. However, sensory impairment limits communication among older adults. Specifically, hearing impairment strains communication via degraded auditory encoding while vision impairment distresses ability to read and interpret visual cues. The presence of dual sensory impairment, defined as concurrent hearing and vision impairment, may exacerbate these effects. The potential consequence s of age-related sensory loss on health care interactions and outcomes are beginning to surface in epidemiologic studies demonstrating poorer patient-provider communication, higher medical expenditures, increased risk of 30-day readmission, and longer length of stay when compared to individuals without sensory loss. Importantly, these associations may be amenable to intervention via sensory aids; however, uptake to sensory care is low. Notably, less than 20% of persons with hearing impairment have hearing aids and over 55% of Medicare Beneficiaries with reported vision problems have not had an eye examination in the prior year. Affordability and access may contribute to lack of sensory care uptake as Medicare explicitly excludes coverage of vision and hearing services. In this symposium, we will review current and new evidence for whether sensory loss affects health care outcomes, including satisfaction with care, incident delirium during hospitalization, navigation of Medicare, and present data on how persons with sensory loss are more likely to delay their care independent of cost and insurance factors suggesting fundamental changes in health care system interaction. We will place these results within the context of current national quality care and policy initiatives and review methods to address sensory loss.

HEARING LOSS AND HELP-SEEKING BEHAVIOR

Nicholas Reed, *Johns Hopkins University, Baltimore, Maryland, United States*

Hearing Loss (HL) is common among older adults and is associated with poor health care quality outcomes include 30-day readmissions, length of stay, poorer satisfaction, and increased medical expenditures. These associations may manifest in changes in help-seeking behaviour. In the 2015 Current Medicare Beneficiary Study (MCBS) (n=10848; weighted sample=46.3 million), participants reported whether they knowingly had avoided seeking care in the past year and self-reported HL was measured as degree of trouble (none, a little, or a lot) hearing when using a hearing aid if applicable. In a model adjusted for demographic, socioeconomic, and health factors, those with a little trouble (OR= 1.612; 95% CI= 1.334-1.947; P<0.001) and a lot of trouble hearing (OR= 2.011; 95% CI= 1.443-2.801; P<0.001) had 61.2% and 101.1% higher odds of avoiding health care over the past year relative to participants with no trouble hearing. Future work should examine whether hearing care modifies this association.

SENSORY LOSS AND DELIRIUM AMONG MEDICARE BENEFICIARIES

Emmanuel Garcia Morales,[1] and Nicholas Reed,[2] *1. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States, 2. Johns Hopkins University, Baltimore, Maryland, United States*

Sensory impairment is prevalent among older adults and may increase risk for delirium via mechanisms including sensory deprivation and poor communication which may result in confusion and agitation. In the Medicare Current Beneficiary Study (MCBS), delirium was measured using a validated algorithm of claims data. Sensory impairment was defined as any self-reported trouble hearing or seeing, with the use of aids, and was categorized as no impairment, hearing impairment only (HI), vision impairment only (VI), and dual sensory impairment (DSI). Among, 3,240 hospitalized participants in 2016-2017, 346 (10.7%) experienced delirium. In a model adjusted for socio-demographic and health characteristics, those with HI only, VI only, and DSI had 0.84 (95% CI: 0.6-1.3), 1.1 (95% CI 0.7-1.7), and 1.5 (95% CI 1.0-2.1) times the odds of experiencing delirium compared to those without sensory impairment. Future research should focus on mechanisms underlying association and determine the impact of treatment of sensory loss.

UNDERSTANDING MEDICARE WITH HEARING LOSS

Amber Willink, *The University of Sydney, Sydney, New South Wales, Australia*

Medicare has become an increasingly complex program to navigate with numerous choices available to beneficiaries with important implications on their financial exposure and access to care. While research has identified poor health literacy as a barrier to understanding Medicare, little information is available on the experience of individuals with hearing loss. Using the Medicare Current Beneficiary Survey (2016), a nationally-representative sample of 10,841 beneficiaries, we examined if difficulty understanding Medicare was associated with reported trouble hearing, while controlling for socio-demographic and health literacy factors. Compared to no trouble, Medicare beneficiaries with a little or a lot of trouble hearing had 44% (95% CI OR:1.34-1.55) and 63% (95% CI OR: 1.44-1.83) increased odds of reporting greater