DEVELOPMENT AND VALIDATION OF THE ANTIPSYCHOTIC MEDICATION RISK SCORE FOR NURSING HOME RESIDENTS

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Prevalence rates of antipsychotic medication (APM) use in U.S. long-stay nursing home (NH) residents, excluding those with approved diagnoses, range from 7.2% to 20.7%; Missouri's rate is 18.6%. This study developed an APM risk score for NH residents using variables from the Minimum Data Set 3.0 (MDS 3.0) assessment. Data from the most recent Missouri MDS 3.0 assessment, excluding admission and discharge, for each long-stay NH resident from November 2017–December 2018 were used to create development (n= 30,893) and validation (n= 7,651) data sets. Potential predictors of APM use were entered in a logistic regression model with variable selection via the least absolute shrinkage and selection operator (LASSO). In a final step, only variables with odds ratios > 1.2 were retained. A weighted score was created by assigning points relative to the maximum coefficient [10*βi /max (β)] and rounded to integer values. APM rates were 17.29% and 17.70% in the development and validation data, respectively. The final model included 14 demographic and clinical indicators; assigned points (1-10) summed for total score (0-50). Areas under receiver operator characteristic curves were 0.801 and 0.798 for the development and validation models, respectively. Youden's index cut-point = 8, with sensitivity of .70 and specificity of .75. Our findings demonstrate it is possible to predict with good accuracy a NH resident's risk of APM use. Identifying residents at increased risk of receiving an APM, perhaps inappropriately, could position NH staff to proactively design and deliver nonpharmacological interventions individualized to each resident's needs and preferences.

DEATH ANXIETY AND FINANCIAL DECISION-MAKING IN AGING: A STUDY FROM THE HUMAN CONNECTOME PROJECT AGING (HCP-A)

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While research addressing late-life death anxiety (the fear of death or the dying process) has focused on end-of-life care decision-making, few have studied the effect of late-life death anxiety on financial decision-making. This is particularly relevant to financial decision-making as older adults are more vulnerable to fraud and deception. The aim of this study was to determine how age and death anxiety affect financial decision-making in a sample of older adults of 60-93 years of age (N = 102), who participated in the HCP-A project at UCLA. To study this relationship, we used a delayed reward discounting task to model financial decision-making, where higher rates of discounting indicate a greater preference for immediate, smaller monetary rewards and lower rates of discounting indicate more future-oriented planning. To account for age-related cognitive decline, cognitive functioning was assessed using the NIH Toolbox. We hypothesized that the presence of death anxiety will increase discounting of future rewards in older adults. Results from a univariate ANOVA showed an interaction between age, death anxiety, and delayed reward discounting. Specifically, older adults with self-reported death anxiety showed greater preference for immediate, smaller monetary rewards. By controlling for cognition, these findings suggest that death anxiety moderates decision-making in late-life adults and may add to our understanding of why older adults are more susceptible to financial abuse. These results suggest a need to consider death anxiety as a moderating variable when developing and implementing policies and services that are geared towards older adults.

USE OF SERVICES BY PEOPLE LIVING ALONE WITH COGNITIVE IMPAIRMENT: A SYSTEMATIC REVIEW

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At least one third of older adults with dementia live alone in the United States. Living alone may represent an opportunity to maintain independence and autonomy, while remaining in a familiar home environment. However, living alone with cognitive impairment is also associated with health risks and unmet needs. No systematic reviews on this population have been published. We systematically reviewed research on use of healthcare and long-term services and supports (LTSS) by people living alone with cognitive impairment. Following PRISMA guidelines, we searched six electronic databases for studies reporting quantitative findings on use of services by people living alone with cognitive impairment; 33 studies met inclusion criteria. Nine countries were represented, all high-income economies. Race/ethnicity data was reported in just five studies, and only one included a majority of racial/ethnic minorities. Overall, people living alone with cognitive impairment appear to use health services at similar or lower rates compared to those living with others; however, LTSS use is higher among people living alone. Representation of non-white participants was poor, but the evidence available suggests that among racial/ethnic minorities with cognitive impairment, there is no difference in LTSS use between those living alone and living with others. Findings highlight inconsistencies in access to and use of essential services by older adults living alone with cognitive impairment. As the populations of the US and other high-income countries become both older and more diverse, with increasing numbers living alone, researchers and service providers must consider the specific needs and preferences of this population.

THE EFFECTS OF SOCIAL NETWORK ON RESILIENCE OF COMMUNITY-DWELLING OLDER ADULTS LIVING ALONE

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