

neutral (n=9; 25%) assessments. Videos created opportunities for patients to pursue their topics of interest during in-person visits. Also, nurses often oriented toward the videos pre-emptively to achieve their teaching goals either by acknowledging the patients' exposure to upcoming information or by positively or negatively assessing the videos in ways that enable them to re-orient talk to educational scripts.

GERIATRIC ONCOLOGY IN THE INSTAGRAM ERA: PHOTOVOICE TO ENABLE PATIENT-CENTERED CARE AND SHARED DECISION MAKING

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Evidence shows that multidimensional assessment of older adults with cancer yields more holistic care and results in better communication about age-related concerns; as well as enables personalised, patient-centered supportive care. Geriatric assessment (GA) captures clinical, physical and psychological factors, with limited opportunity to gather information about the patient's environment, personal contexts and priorities. We trialed the feasibility and acceptability of geriatric assessment (GA)-guided enhanced supportive care (ESC) among 20 adults aged over 70 years in a regional cancer center. We then studied the impact of the integration of four patient-derived photographs (with PhotoVoice analysis) to this ESC on patient satisfaction with communication with the oncologist regarding age-related concerns and on facilitating empowerment, patient-centered care and shared decision making. The use of PhotoVoice analysis of patient-derived photographs is a novel strategy that can facilitate gathering patient-centered information during the assessment process.

Session 1095 (Paper)

Mobility I

FACTORS ASSOCIATED WITH OLDER ADULTS' IN-HOSPITAL MOBILITY: A COMPARISON BETWEEN ISRAEL AND DENMARK

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Low levels of in-hospital mobility and excessive bed rest are widely described across the globe as a major risk factor for hospital associated disabilities. Different predictors of in-hospital and post-discharge mobility limitations have been proposed across studies, including age, admission diagnosis, physical performance, cognitive impairment, performance of activities of daily living, and length of stay. However, it is unknown whether similar risk factors across countries are associated with in-hospital mobility given different mobility measurement methods, variations in measurement of predictors and differences in populations studied. In the current study, we investigated the relationship between in-hospital mobility and a set of similar risk factors in functionally independent older adults (65+) hospitalized in acute care settings in Israel (N=206) and Denmark (N=113). In Israel, mobility was measured via ActiGraph and in Denmark by ActivPal for up to seven hospital days. Parallel analysis of covariance (ANCOVA) in each sample showed that community-mobility before hospitalization, mobility performance at admission and length of stay were associated with in-hospital mobility in both countries, whereas age and self-reported health status were associated with mobility only in Denmark. This comparison indicates that despite slightly different measurement approaches, similar risks are attributed to older adults' low in-hospital mobility and emphasizes the contribution of commonly used pre-hospitalization mobility measures as strong and consistent risk factors. This knowledge can support a better understanding of the need of both standard risk assessments and country-based tailored approaches.

MACHINE LEARNING PREDICTION MODELS FOR MOBILITY LIMITATION OVER TIME IN OLDER ADULTS: THE HEALTH ABC STUDY

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Mobility limitation in older adults is common and associated with poor health outcomes and loss of independence. Identification of at-risk individuals remains challenging because of time-consuming clinical assessments and limitations of statistical models for dynamic outcomes over time. Therefore, we aimed to develop machine learning models for predicting mobility limitation in older adults using repeated measures and variable selection. We used nine years of follow-up data from the Health, Aging, and Body Composition study to model mobility limitation, defined as self-report of any difficulty walking ¼ mile or up a flight of stairs, assessed annually. We considered 46 predictors for modeling, including demographic, lifestyle, chronic condition and physical function variables. We developed three models with Binary Mixed Model Forest, using: 1) all 46 predictors, 2) an automated variable selection algorithm, and 3) the top five most important predictors. Area under the receiver operating curve ranged from 0.78 to 0.84 for the models for two validation datasets (with and without previous annual visit data for participants). Across the three models, the most important predictors of mobility limitation