at UMass Medical School (UMMS) are demographically representative of the national patient population. If not, medical students are missing the opportunity of experiencing normal variation within the population, which may promote bias in their clinical years. This cross-sectional study compared data from the UMMS Anatomical Gift Program (AGP) with the Health and Retirement Study (HRS) population data. This study examined sex, race, ethnicity, veteran status, and sexual orientation. 5 years (n=540) of AGP data and 3 waves (n=5,037) of HRS data were examined. The results demonstrate that sex differences between the AGP and HRS populations (55% for females vs. 45% for males; p=.10) are NOT significant. A significant racial difference between populations is noted (p=.000), with 98.3% of the AGP vs. 72.7% of the HRS identifying as white. Veterans are overrepresented in the AGP (22.6% AGP vs. 9.6% HRS; p=.000). 12.3% of HRS participants report Hispanic ethnicity compared to 0% in the AGP. In 2016, HRS included sexual orientation, with 92.7% of respondents identifying as heterosexual, 2.6% gay or lesbian, 1.0% bisexual and 1.3% other. No data were collected by the AGP pertaining to sexual orientation and neither database ask about gender identity. Aging populations are not represented in the anatomy labs at UMMS and likely nationally. Efforts are needed to improve this and enhance the education of the medical professionals, while expanding the end-of-life options for all community members.

ASSOCIATION BETWEEN LONELINESS AND DISEASES SELF-MANAGEMENT IN OLDER ADULTS: SYSTEMATIC REVIEW

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Purpose: Older adults with chronic diseases are more at risk for loneliness, and loneliness has a negative impact on health behaviors, which are key to managing chronic diseases. However, little is known about the association between loneliness and self-management behaviors in older adults with chronic diseases. As societies worldwide experience the growth of aging populations who are at higher risk of having chronic diseases as they age, clinicians and researchers should assess and address loneliness of older adults with chronic diseases. Methods: This systematic review synthesizes research found in PubMed, MEDLINE, PsychINFO, CINAHL, and SocINDEX. Findings: fourteen studies were conducted in four countries and represented n= 128,610. Loneliness was measured by three different instruments. Reports of loneliness were frequent and ranged from 7.7% (in a report of severe loneliness) to 43.2% (moderate loneliness) of older adults. Older adults who experienced loneliness were less likely to be physically active, eat a healthy diet, or cope in positive ways and more likely to be female and seek healthcare. Conclusions: This systematic review found that loneliness was moderately prevalent, and that loneliness was associated with negative disease self-management behaviors in older adults with chronic diseases. Gaps in the research include a need for studies guided by theoretical pathways, using a consistent, theoretically-based measure of loneliness, and conducted on among people with specific chronic diseases.

ASSOCIATION OF SOCIAL DETERMINANTS, MULTIMORBIDITY, AND FUNCTIONAL STATUS WITH MORTALITY AFTER PNEUMONIA

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Social support, multimorbidity, and functional status are important determinants of health in older adults, but their prognostic implications remain unclear after an acute illness. We conducted a prospective cohort study of 201 patients 65 years or older who were hospitalized for pneumonia at a university hospital in Korea in 2019-2020. K-means cluster analysis was performed using social deprivation score (range: 0-5), activities of daily living (range: 0-7), instrumental activities of daily living (range: 0-7), physical limitation score (range: 0-7), and Gagne comorbidity index (range: 0-24) (higher scores indicate higher risk). Four groups were identified: 1) Group A: physically limited and non-disabled group with limited social support; 2) Group B: multimorbid but functional group with social support; 3) Group C: multimorbid and disabled group with social support; 4) Group D: multimorbid and disabled group with limited social support. For Groups A through D, the Kaplan-Meir estimates for 6-month mortality were 10.0%, 18.0%, 34.2%, and 43.6%, respectively, and the 6-month mean survival times were 166.4 days (95% CI: 156.1-176.6), 156.9 days (95% CI: 140.8-173.1), 145.2 days (95% CI: 126.6-163.8), and 125.9 days (95% CI: 107.7-144.1), respectively. After adjusting for sex, age, and pneumonia severity score, the hazard ratios for Groups B through D versus Group A were 2.07 (95% CI: 0.70-6.13), 3.14 (95% CI: 1.17-8.42), and 4.38 (95% CI: 1.73-11.04), respectively. Our results suggest that multimorbidity and disabilities were implicated in higher risk of 6-month mortality after pneumonia, and social support may mitigate this risk among those with multimorbidity and disability.

CHRONIC DISEASES AND SELF-REPORTED HEALTH STATUS AMONG AMERICAN INDIAN/ALASKA NATIVE OLDER ADULTS

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Background: In the 1800s and 1900s, U.S. federal "Indian" policy (e.g., boarding schools, relocation) created historical trauma with impacts that reverberate today, such as the significant health challenges experienced among American Indian/Alaska Native (AI/AN) populations. Our study seeks to better understand the burden of chronic disease, and also resilience, among AI/AN older adults. Methods: Data came from Cycle VII (2018-2020) of the National Resource Center on Native American Aging's "Identifying Our Needs: A Survey of Elders" survey of AI/AN adults ages 55+ from primarily rural tribal survey sites (N=20,642). Analysis explored self-assessed health