1=low-MetS (28.7%), 2=mid-MetS (30.9%), >3=high-MetS (16.5%). High-MetS versus none had higher body mass index, pain, financial strain, and lower physical activity and self-reported health ($p < 0.0001$). Black and Hispanic women were more likely to be in high-MetS and had worse physical functioning, along with Chinese women, versus White (all $p<0.05$, except gait speed in Hispanic). Adjusted linear regression related MetS groups to physical performance. High-MetS versus none demonstrated adjusted worse 40-ft walk (β:-0.08; 95% CI:-0.13, -0.03), gait speed (β:-0.09; 95% CI:-0.15, -0.02), SPPB (β:-0.79; 95% CI: -1.15, -0.44), and chair stands (β:0.69; 95% CI: 0.09, 1.28), but not stair climb, with race significantly related to all except 40-ft walk. Midlife MetS trajectories related to poor physical performance in early late life multi-ethnic women. Managing midlife metabolic function may improve physical performance in late life.

MOBILIZING ELDERS: AN INTERPROFESSIONAL EFFORT

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Older adults often experience functional decline during hospitalization as a result of immobility. Such decline has associated adverse outcomes, including gait instability, falls, pressure injuries, delirium, and new nursing home admissions. Our objective was to create an effective and sustainable in-hospital mobility program through enhanced interdisciplinary cooperation in an Acute Care of the Elderly (ACE) unit. An interdisciplinary team at UNC's 25-bed ACE unit planned and delivered enhanced patient mobility beginning in July 2020. We used an input-process-output model to design and analyze an intervention based on enhanced collaboration. Inputs included a mobility taskforce which was comprised of physicians, nurses, physical and occupational therapists, and quality improvement specialists. Through regular meetings, each taskforce member contributed to the study design and were empowered to identify barriers to implementation. Outputs included stakeholder engagement and mobility rates. Early results show a doubling in mobility rates over a 6-month period with consistent and enthusiastic stakeholder engagement. Observations of such benefits include: a) stakeholder inclusion from each discipline ensured implementation that was pragmatic and easily incorporated into the daily workflow; b) mobility champions regularly disseminated information to their respective disciplines, leading to changes using a quality improvement process; and c) barriers to implementation were rapidly identified, and mobility champions were motivated to find solutions, allowing cohesive incorporation of a broad spectrum of priorities. An interprofessional team model is effective to mobilize hospitalized older adults, potentially reducing adverse hospital outcomes. Successful implementation of such programs is dependent on interprofessional collaboration.

MODERATORS OF DUAL TASK GAIT EFFECTS IN MILD COGNITIVE IMPAIRMENT AND DEMENTIA

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Spatiotemporal gait parameters may provide indication about the cognitive status of individuals. Dysfunction in specific gait features has been associated with increased risk of cognitive decline. Here we use spatiotemporal gait patterns to determine whether specific cognitive domain scores moderate the effects during dual-tasking on individuals with mild cognitive impairment (MCI) and dementia. Participants (n=46; mean age: 77.0±8.9 years) with a diagnosis of cognitive impairment (n=16), or dementia (n=30) were included. They performed validated computerized cognitive assessment battery (CAB, NeuroTrax BrainCare) to obtain cognitive domain measures of executive function (EF), attention, memory, visual-spatial processing (VSP), information processing speed (IPS), and a global cognitive score (GCS) measure. Using the Zeno Walkway Gait Analysis System (Protokinetics), measures of velocity, stride width (SW), stride time (ST), stride length, cadence, double support (DS), and gait variability were obtained for both single-task and DT gait. Data analysis was conducted using SPSS 26 and PROCESS 3.5. As expected, the dementia group had lower cognitive domain scores and slower walking speed than MCI group. Results also indicated that visual-spatial processing skills was the only cognitive domain that did have a moderation effect on gait velocity ($F=4.2$, $p<0.05$, R-square change 10%). Our results indicate that differences between walking speed in MCI and dementia groups are moderated by visual spatial skills. Improvement in visual spatial skills could improve the dual task effects of individual gait measures.

PERSISTENT DISABILITY SIX MONTHS AFTER INITIAL DISABILITY LESS LIKELY IN OLDER WOMEN

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Many community-dwelling older adults develop activity of daily living (ADL) disability and subsequently regain function. Using data from the ASPirin in Reducing Events in the Elderly (ASPREE) clinical trial, we examined the relationship of gender, incident disability, and persistent disability 6 months after the incident disability. Walking, bathing, dressing, transferring, toileting, and eating were assessed as ADLs, at bi-annual interviews. ADL disability was defined as requiring help with or inability to do or severe difficulty with ≥1 ADL; persistent disability was an ADL loss at 6 months after a first (incident) ADL disability. Discrete time, multivariable Cox proportional hazards regression was utilized to estimate associations with developing incident ADL disability described as cause-specific hazard ratios,