and knowledge promoted advance care planning. Illness awareness, perceived barriers about advanced care planning, knowledge, access to medical care (esp palliative) influenced decisions about EOL and hospice, not one's ethnicity. Patient & family education by health professionals led to increased awareness of disease and better EOL decision making. The international studies revealed the following: In a Korea study most subjects viewed advance directives positively which was not influenced by information disclosure, ICU experience, prognosis or gender. In a Taiwan study, knowledge of palliative care & hospice increased willingness to execute advance directives & many elderly cancer patients preferred to die at home with hospice care in their last year. In a China study, less awareness of prognosis increased anxiety and communication difficulties with family members.A survey of Chinese medical interns felt they had received insufficient palliative care education in medical school. Both individualistic and family autonomy models were observed in the US and International studies.

Conclusion: Ethnicity or geography did not influence decisions regarding EOL, hospice, palliative care and advance directives. Rather, education and awareness improved outcomes. Asian populations both in the US and internationally could benefit by having active dialogue among health care professionals, patients and families. Clinicians should be more culturally sensitive in accepting a family-centered decision making process along with the autonomy model

A98

Neighborhood Socioeconomic Disadvantage and Walking: the Cardiovascular Health Study.

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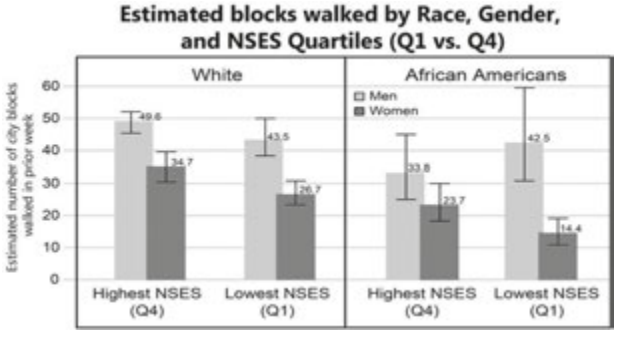
Background: We examined the association between neighborhood socioeconomic status (NSES) and walking in older adults and assessed variation in the relationship by race and gender.

Methods: We used data from the Cardiovascular Health Study, a multicenter study of cardiovascular disease in older adults 65 years and older, to examine the association between NSES (the summed z-scores of census variables representing income, wealth, education and employment) and self-reported blocks walked in the prior week. We constructed race- and gender-stratified multilevel binomial models adjusted for clustering by NSES quartile, sociodemographic, behavioral, and clinical characteristics.

Results: The sample included 4005 whites (57% female) and 844 African Americans (62% women). Overall, adjusted mean blocks walked was higher among whites than African Americans and among men than women ($p<0.05$). Among African Americans, women in the lowest NSES neighborhoods walked fewer blocks relative to men than women in the highest NSES neighborhoods, while the relationship between NSES and blocks walked did not differ for white men and women.



A99

Prognosis of nursing home patients with dementia: a systematic review.

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Background: More than 70% of dementia-related deaths occur in the nursing home, yet, most patients do not qualify for hospice using the FAST (Functional Assessment Staging) criteria required by Medicare.

Objectives: To review the literature reporting prognostic data among nursing home patients with dementia.

Methods: We conducted a systematic review of online databases using the standard search terms to identify studies reporting mortality among nursing home residents with dementia. We identified 1846 candidate articles and 43 met inclusion criteria.

Results: The 43 articles reported mortality at variable time intervals: 8 reported 3-6 months mortality of 17.5- 40.4%; 10 reported 12 month mortality of 17-38%; 2 reported 18 month mortality of 26.3-54.8%; ten reported 24 month mortality of 33.8-53%; and 13 articles reported mortality ≥24 months with mean survival ranging from 22.4-30 months. The most common factors associated with mortality were gender (cited by 15), functional dependence (12), age (15), dementia severity (11), pressure ulcers (7), pneumonia (5), malnutrition (8), and bedfast/body posture (5). Only 7 articles developed a prognostic index and only three reported AUROC (area under the receiver operating characteristic) for six month mortality. The first article used MDS data and the following criteria: complete ADL dependency, male, cancer, use of oxygen, CHF, shortness of breath, eating <25% at most meals, unstable condition, bowel incontinence, bedfast, age >83 years old, and not awake most of the day. The AUROC curve for predicting six month mortality was 0.74 and 0.70 for the derivation and validation cohorts, compared to 0.51 for the FAST stage 7c. The second study used the same risk score (ADEPT) to estimate six month mortality in long-stay residents with advanced dementia. The AUROC was 0.65 for one cohort and 0.64 for the cohort in which residents also had a lower respiratory tract infection. The third study published in 2010 used the same risk score (ADEPT) in a prospective cohort study. The AUROC for the ADEPT score was 0.67 compared to 0.55 for Medicare FAST.

Conclusion: While many studies report descriptive data regarding the high mortality rate among nursing home residents with dementia, there is still limited ability for clinicians to prognosticate 6 month mortality.

A100

Non-malignant pain management and NSAIDs use in older patients: US outpatient settings.

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Background: AGS guidelines for persistent non-malignant pain management in older adults recommend acetaminophen as a first line agent for mild to moderate pain. In inflammatory pain processes, NSAIDs are used for short term relief, however they posess a higher potential for side effects in older adults. Opioids and adjuvant agents are recommended for moderate to severe pain or pain that causes functional impairment or diminishes quality of life. About 23% of hospital admissions for older adults in the USA occur due to adverse drug reactions (ADRs) related to NSAIDs. We investigated national prescription trends for non-malignant pain management among older