In Canada, adults 85 years and older represent one of the fastest growing segments of the population[1]. Mood disorders and chronic illness often intersect, worsening health outcomes in late life[2]. In view of demographic trends, medical schools should ensure trainees are equipped with the knowledge, skills and attitudes to work with older adults. However, there continues to be much variation in how medical schools incorporate geriatric content into their curricula.

In 2009, the Canadian Geriatrics Society (CGS) outlined 20 competencies in geriatrics to inform medical school curricula, but uptake was minimal. Of note, there were significant gaps in these competencies, which omitted mention of late-life depression. Geriatric mental health experts did not provide input.

The objective of this project was to address gaps in geriatric competencies for medical students through an expert review process involving a biopsychosocial approach.

Methods: The CGS established a 15-member national working group with representation from geriatric psychiatry, family medicine, a 95-year-old senior, geriatrics and medical trainees. Potential competencies were derived from existing Canadian geriatrics frameworks [Geriatrics 5M, CanMEDs] and 2009 competencies. A modified Delphi process yielded rankings for each competency using a 7-point Likert scale.

Results: Between 2019 and 2021, 3 successive national surveys were completed. In the first (n=66), 34 competencies were identified. Agreement in the final survey was 87-95% (mean 90%). 51 participants completed all three. Significant topic omissions in the 2009 list of competencies were frailty, end-of-life care, delirium prevention, health promotion and the assessment and management of depression.

Conclusions: Three national surveys expanded the core competencies in geriatrics for medical school curricula from 20 to 31. Expert consensus was high. Themes mapped along existing geriatrics frameworks and incorporated a holistic lens incorporating the perspectives of an older adult and geriatric psychiatrist. In addition to late-life depression, the importance of addressing ageism was also highlighted.

Learning objectives for each competency are modifiable for level of training and individual program, offering flexibility. The CGS will continue to advocate for inclusion of updated, expanded competencies into training and licensure in geriatrics.

1) Statistics Canada 2021, Canadian Government, accessed 1 January 2023, <. Accessed 20/01/23 <https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021004/98-200-x2021004-eng.cfm>
2) Hall CA, Reynolds III CF. Late-life depression in the primary care setting: challenges, collaborative care and prevention. Maturitas. 2014 Oct; 79(2):147-52.

FC9: Ethno-racial identity and cognitive impairment: A population-based study

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Objective: Health disparities between communities with greater and lesser advantages are a global concern. In the USA, self-identified race as African American (AA) is consistently associated with mild cognitive impairment (MCI) and dementia, compared to Americans of European descent. In a prospective population-based study, we sought to confirm this association and investigate potential explanatory factors.

Methods: The Monongahela-Youghiogheny Healthy Aging Team (MYHAT) and Seniors Project 15104 (SP15104) studies recruited adults aged 65+ years from a group of small towns of lower socioeconomic status in the US. MYHAT recruited by age-stratified random sampling from the voter registration list for all towns; SP15104 recruited by intensive community engagement from three towns with populations that are 60% AA. Based on the Clinical Dementia Rating (CDR), MCI was defined as CDR=0.5 and dementia as CDR > 1. Using Cox proportional hazard models, we modeled time to incident CDR > 0.5 from baseline as a function of race (AA vs. all other), other demographics, and several other covariates at baseline.

Results: The sample of 2120 individuals was 8% AA, and 62% female, with median age of 73y, and median educational level of partial college. During follow up of up to 14.5 years, 499 participants developed new-onset MCI/dementia (CDR >0.5). Cox models revealed that being AA was significantly associated with incident CDR > 0.5 (HR=1.45. 95% CI:1.01,2.10). Inclusion of age, sex, and education in the model increased the HR for race to 1.63 (1.1, 2.3). Adding number of regularly taken prescription drugs (reflecting overall morbidity), depression symptoms, preceding year alcohol consumption, and number of visits to emergency or urgent care together reduced the HR to 1.4 (0.96, 2.0), no longer statistically significant

Conclusions: In this population-based cohort study, self-identified African Americans had an about 40% elevated risk of developing MCI/dementia. Adjusting for demographics, the significant association between race and incident MCI/dementia was attenuated by variables reflecting depression, greater general morbidity, and lesser access to regular health services. These variables possibly reflect downstream effects of historic discrimination, but couldstill be modifiable risk factors for MCI/dementia. Addressing them could potentially mitigate ethno-racial disparities in cognitive impairment.

FC10: Telehealth for Older Adults: Developing telehealth competencies to ensure access, quality and equity across the lifespan

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Background: Telehealth has been an important method of health care delivery during the pandemic, particularly for older adults who have been more vulnerable to the physical and psychosocial impacts of the pandemic and associated isolation. Older adults have specific medical and mental health care needs that would benefit from having access to geriatric speciality services, however these services may be difficult to access especially for those living in rural areas. Though the use of technology and telehealth has greatly expanded during the pandemic,

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