PARTITIONING OF TIME TRENDS IN PREVALENCE OF LUNG CANCER AMONG OLDER U.S. ADULTS

I. Akushevich, A. Yashkin, F. Fang, J. Kravchenko, A.I. Yashin, Duke University, Durham, North Carolina

The time trend of lung cancer prevalence is the result of three competing processes: changes in the incidence rate, stage-specific survival, and ascertainment at early stages. In this report we present a new approach to the evaluation of the contribution of each of the above components to the overall prevalence trend. Using SEER data, we found that the prevalence of lung cancer increases for females and decreases for males over the study period (1988–2013). The increase for females is due to increased incidence (explains approximately 45–50% of total trend) and improved survival (40–45% of total trend). The remaining 10–15% are explained by increased ascertainment at early stages. For males, the effect of increased survival is compensated by a rapidly declining incidence rate resulting in an overall decrease in prevalence over time. Application of the partitioning approach to histotype-specific prevalence (i.e., for adenocarcinoma, squamous-cell carcinoma, small-cell carcinoma) showed that these patterns held for histotype-specific cancers with the following exceptions: i) since 2005, adenocarcinoma incidence increased for males resulting in its higher prevalence; ii) ascertainment at early stages impacts the trends of squamous-cell and small-cell carcinoma more than adenocarcinoma. The results suggest an increasing role of adenocarcinoma in lung cancer trends in the era of smoking cessation and lower effects of early ascertainment on cancer outcomes. This is important for improvement of cancer preventive strategies and more efficient use of the current funds available to the Medicare program, thus potentially increasing its cost effectiveness and by extension durability.
in China may be associated with reduced risk of functional limitations, and RR=0.86 for IADL limitations, with statistically significant inverse associations with all three outcomes of incident functional limitations included three outcomes: any newly reported difficulties with (1) physical functions, (2) activities of daily living (ADL), and (3) instrumental activities of daily living (IADL). The cohort ranged in age from 45 to 101 years, with 51.6% female, with 36.2% received financial support and 69.1% perceived instrumental support. At baseline after adjusting for age, those who received financial support tend to be older, female, less educated, rural, and have more children and poorer health. Those who perceived instrumental support tended to be female, rural, and have better self-rated standard of living and better health. Using multiple Poisson regression adjusting for age, gender, demographic characteristics, socioeconomic status, and baseline health, both received financial support and perceived instrumental support had statistically significant inverse associations with all three outcomes of incident functional limitation (e.g. for perceived instrumental support, RR=0.83 for physical limitations; RR=0.77 for ADL limitations, and RR=0.86 for IADL limitations, p<.01 for all). Our results suggest that forms of social support in China may be associated with reduced risk of functional decline in Chinese older adults.

THE ROLE OF SOCIAL SUPPORT IN INCIDENT FUNCTIONAL LIMITATIONS AMONG CHINESE OLDER ADULTS
L. Zhang, F. Grodstein, L. Berkman, Epidemiology, Harvard T.H. Chan School of Public Health, Roxbury Crossing, Massachusetts

We explored the associations between forms of social support and incident functional limitations in Chinese older adults, using a nationally representative sample (n=17,174) in the China Health and Retirement Longitudinal Study (CHARLS) upon 2 year follow-up. Social support was evaluated at baseline as (1) received any financial support from family within the last year, and (2) perceived availability of instrumental support with basic functions like eating or dressing if needed. Incident functional limitations included three outcomes: any newly reported difficulties with (1) physical functions, (2) activities of daily living (ADL), and (3) instrumental activities of daily living (IADL). The cohort ranged in age from 45 to 101 years, with 51.6% female, with 36.3% received financial support and 69.1% perceived instrumental support. At baseline after adjusting for age, those who received financial support tend to be older, female, less educated, rural, and have more children and poorer health. Those who perceived instrumental support tended to be female, rural, and have better self-rated standard of living and better health. Using multiple Poisson regression adjusting for age, gender, demographic characteristics, socioeconomic status, and baseline health, both received financial support and perceived instrumental support had statistically significant inverse associations with all three outcomes of incident functional limitation (e.g. for perceived instrumental support, RR=0.83 for physical limitations; RR=0.77 for ADL limitations, and RR=0.86 for IADL limitations, p<.01 for all). Our results suggest that forms of social support in China may be associated with reduced risk of functional decline in Chinese older adults.

SESSION 2245 (SYMPOSIUM)
THREE MODELS OF INTEGRATING GериATRICS INTO PRIMARY CARE: GERIATRIC WORKFORCE ENHANCEMENT PROGRAMS
Chair: C. Clarke, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina
Co-Chair: S. Hardin, East Carolina University, Charlotte;
M. Heflin, Duke University, Durham, North Carolina

Critical shortages in Geriatricians require innovative training models. The Health Resources and Services Administration has funded 44 Geriatric Workforce Enhancement Programs (GWEPs) nationally with the mandate to integrate geriatrics into primary care. In this session the North Carolina GWEP programs describe three approaches to partnering with a variety of primary care practices to enhance the quality of care for older adults across settings such as rural solo practice's offices, federally qualified health centers and urban group practices embedded in large health systems. Each program design is unique and context dependent however session attendees will glean useful strategies to apply in their own settings.

INTEGRATING GериATRICS INTO PRIMARY CARE THROUGH A PRACTICE MANAGEMENT EFFICIENCY APPROACH
C. Clarke, J. McBride, T. Shubert, E. Roberts, J. Busby-Whitehead, School of Medicine, Division of Geriatrics, Center for Aging and Health, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Background: Critical shortages in Geriatricians require innovative training models. The Health Resources and Services Administration funded three 3 Geriatric Workforce Enhancement Programs in North Carolina to integrate geriatrics into primary care. Building upon previous curricula, the University of North Carolina at Chapel Hill (UNC-CH) is moving training into clinical settings: an internal medicine residency clinic, a corporately owned family practice clinic and federally qualified health centers.

Methods: Because significant barriers exist to the adoption of evidence-based geriatrics in a busy practice, UNC-CH chose a bottom-up approach. To increase the adoption each practice chose one geriatrics syndrome and UNC-CH aligned practice change effort with community needs and pre-existing quality indicators. Structured evaluations of workflows and training gaps were conducted to identify efficiencies. Evaluation metrics included: measuring patient referral patterns and staff confidence and efficiency in managing their geriatric patients, pre and post intervention. New protocols were developed and tested using a plan, do, study, act (PDSA) methodology. Population based and individual evaluation metrics were developed collaboratively.

Results: Some increased efficiencies were noted with changes in workflow patterns. Whole team training allowed paraprofessional staff to actively support patient screening for geriatrics syndromes. Increased patient referrals were documented.

Conclusions: Training of paraprofessional staff can lead to improved screening for geriatric syndromes. Practice change efforts to enhance geriatrics in primary care are most