examine the psychological impacts of COVID-19 on older informal caregivers.

IMPACT OF VIBRATION ON TREMOR IN OLDER ADULTS WITH PARKINSON’S DISEASE

This was a randomized trial to explore the safety and efficacy of the RMBand (Resonate Forward LLC, Delaware) device to alleviate Parkinson’s Disease (PD) tremors. The RMBand applies vibration to the proximal arm and was worn on the side of tremor dominance. Thirty subjects with PD and associated tremors were randomized to receive high vs. low-frequency vibration. Tremor assessments occurred for 20 minutes before, during 20 minutes of continuous vibration, and for 20 minutes immediately post-vibration in a single 60-minute session. Assessments (MDS-UPDRS part 3 and FTM tremor scale) were performed during each of the 3 phases by blinded raters. A quantitative assessment of tremor was performed throughout the session using wearable sensors on the distal arms. Linear mixed models were used for group comparisons. No significant difference was observed between the high and low dose groups in the MDS-UPDRS part 3 or FTM tremor scale (p=0.83 and 0.48 respectively), which may be due to the crude nature of these scales. Quantitative wearable sensor data were used to assess total time with tremors during the pre-vibration, vibration, and post-vibration periods. Time with tremor during the pre-vibration period was significantly greater than that during and post-vibration (p< 0.0001) for both dose groups, suggesting that vibration therapy applied to the proximal arm may suppress PD tremor. No significant adverse events related to vibration therapy occurred. In conclusion, the RMBand appears safe and possibly effective for suppressing PD tremor. Further study is warranted.

IMPROVING HOME-CARE SERVICES FOR HIGH-RISK OLDER ADULTS USING PEER-LED VIDEO VISITS TO HOME
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Older Veterans at high-risk for institutionalization often require home- and community-based services (HCBS). Yet, current HCBS delivery often fails to meet the needs of high-risk Veterans due to decreased veteran engagement in outpatient programs and limited HCBS capacity. A promising approach to address these gaps is the use of Veteran-Peers to make home-visits. Peer-2-PACT is a peer-led needs-assessment intervention for high-risk older veterans. Two trained peers conducted a checklist-guided virtual and/or in-person home-assessment to identify unmet needs and home-safety concerns. Veterans with access, acceptance and ability for video-capable technology were offered video-visits. We report on the feasibility of video home-visits in this high-risk group, and the experience of the video-visits using the visit-data and interviews with peers. Eight of 27 Peer-2-PACT Veterans successfully completed initial video-visit to home. The video-visit participants (n=8) were age 74±9; Non-Hispanic Black (50%); males (100%), compared to initial in-person home-visit participants (n=19), age 75.3±10.8; Non-Hispanic Black (47%); males (89%). The commonest needs identified during video-home-visits were home-safety devices 5(62.5%), housing assistance 4(50%), and medication refills 2(25%). Peers report that identifying veterans suitable for video-visits was challenging. During video-visits, depth-perception by peers is limited and sometimes needed in-person follow-up. Main advantages of video-visits was ability to identify unmet needs, engage veterans, provide care during COVID, and tele-present to remote clinicians. Preliminary data suggest that peer-conducted video home-visits is a feasible way to identify unmet needs in some high-risk older adults. This is particularly important improve care of Veterans who live at a distance from the facility.

DOES AGE, RACE, AND/OR RURALITY DETERMINE OLDER VETERANS’ ABILITY TO ACCESS VA VIDEO CONNECT

The purpose of this project was to determine whether ability to use VA Video Connect (VVC) by older Veterans (OV) differed by age, race, or rurality. A service to help older Veterans learn to use VVC was developed. As part of an ongoing QI project, demographics, willingness to attempt a VVC test call and outcomes of test calls were collected on all referrals. Descriptive statistics, Chi-square, and Fisher’s exact test were used to examine differences in success rates by group. Of the 66 OV (age 60+) referred by their primary care providers, we were able to contact 63 by phone. Of those, 46 (73%) scheduled a VVC test call, 7 (11%) chose not to participate, and 10 (16%) were already using VVC for appointments. Of the 40 who continued the VVC test call, 31 (77.5%) were successful without issues, 7 (17.5%) were successful with help resolving issues, and 2 (5%) disconnected before finishing the call because it became too difficult. Of the 63 OV contacted, 38 (57.5%) had a successful VVC test call. However, those residing in rural (vs. urban) settings were less likely to have a successful test call (43% vs. 57%, p=0.04). There was no statistically significant difference in