

between race, advance care planning (ACP), and quality of care among persons with ADRD. The aim of this study was to (1) characterize trends in both ACP and EOL treatment intensity in persons with ADRD and (2) test whether racial differences in ACP mediate disparities in EOL care. We analyzed a population-based cohort of older adults with cognitive impairment or dementia who participated in the Health and Retirement Study (HRS) and died between 2000 and 2014 ( $n = 5,316$ ). While participation in ACP among persons with ADRD increased from 2000 to 2014 (66% to 83%,  $P < 0.05$ ), models stratified by race showed that differences in participation rates across white and nonwhite persons with ADRD persisted over the sample period. Racial disparities in the location of death, a proxy for the intensity of EOL care, narrowed from 2000 to 2014. However, next-of-kin surrogates of nonwhite persons with ADRD were much more likely to report the decedent received “all care possible... in order to prolong life”. Assignment of a durable power of attorney was found to influence location of death, while both creation of a living will and participation in discussions about EOL care preferences were found to influence the likelihood that decedents received all possible life-prolonging treatments.

#### REASONS FOR NON-PARTICIPATION IN AN ACTIGRAPHY STUDY IN AN ALZHEIMER'S DISEASE CENTER REGISTRY

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When recruited individuals decline to participate in research, it can lead to sampling bias, increased costs, and extended duration of data collection. Understanding reasons why eligible participants decline participation may improve study enrollment rates. We aimed to understand barriers to recruitment and data collection in older adults with and without Alzheimer's disease in the University of Kansas Alzheimer's Disease Center Registry annual visit. We recruited Registry participants to join an observational sub-study using wrist-worn actigraphy to measure physical activity and sleep. We analyzed reasons for non-enrollment from encounters with non-participating individuals. Of 104 encounters, 37 were never recruited due to appointment cancellation, rescheduling, or no-show. Of the remaining encounters, the most common reasons for non-participation were physical limitations ( $N = 13$ ), study logistics (e.g., limited supplies;  $N = 12$ ), participant travel plans ( $N = 10$ ), and unknown ( $N = 8$ ). Other categories ( $N = 6$ ) included disinterest, study partner concerns about pragmatics (e.g., fear that an individual with AD would lose the ActiGraph), problems with the study design (e.g., lack of feedback to participants), and participants' limited availability or deferment to a later date. These findings offer insight into potential avenues to overcome barriers to participation in older adults already engaged in ongoing research through an Alzheimer's Disease Center Registry. Researchers could benefit from adapting study procedures to correct for reasons of non-participation. For example, giving more education and reassurance to potential participants about observation and giving feedback regarding activity patterns.

#### STIGMATIZATION AND THE EXPERIENCE OF INFORMAL DEMENTIA CAREGIVERS IN NIGERIA

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There is no formal word for dementia in Nigeria. Instead, some Nigerians, in their effort to make sense of dementia symptoms, use descriptions that may result in stigmatization of people living with dementia and their families. With Nigeria's rapid aging, increased risk of dementia, and lack of formal long-term care, this study focused on the impact of stigma on the caregiving experiences of Nigerian women. This exploration is significant as adult females in Nigeria are the pillar of informal caregiving in the country. The study employed a qualitative descriptive method. Semi-structured interviews were conducted with a purposive sample of 12 adult informal female caregivers in Anambra, Nigeria. Data were then transcribed, coded and analyzed for themes. Afterwards, focus groups of 21 adult Nigerians residing in Ohio, US, were conducted to offer more contextual insight on the findings. The three major themes identified were: 1) negative views of dementia symptoms (e.g., witchcraft, madness), 2) caregiving protects against stigmatization (e.g., by keeping family members out of sight), and 3) stigma and caregiving support such as adult children abandoning parents with dementia because of the stigma associated with dementia. Given the overwhelming presence of stigma in all aspects of dementia to include dementia caregiving, results point to the critical need for better strategies to help strengthen informal caregiving in Nigeria. This includes culturally appropriate dementia education for families and caregivers, and formal long-term care policies that include care support in a rapidly aging Nigeria.

#### STIGMATIZING BELIEFS ABOUT ALZHEIMER'S DISEASE IN DIVERSE ETHNIC GROUPS OF ASIAN AMERICANS

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Cumulative studies have investigated Alzheimer's disease (AD)-related issues among Asian Americans, but few have considered ethnic diversities within the Asian group. Using an ethnic-diverse Asian American sample, the present study explored the prevalence, ethnic variations, and predictors of stigmatizing beliefs about AD: (1) AD is a normal process of aging, (2) it is embarrassing to have a family member with AD, and (3) social interactions with an AD patient should be avoided. Inspired by the sociocultural health beliefs model, a focus was given on the role of immigration and culture-related variables. Using data from the 2015 Asian American Quality of Life survey ( $N = 2609$ , age range = 18-98) that includes Chinese, Asian Indian, Korean, Vietnamese, Filipino, and other Asians, logistic regression was conducted to examine how each of the three stigmatizing beliefs would be predicted by (1) demographic variables and (2) immigration and culture-related variables. Results indicate that the prevalence of the stigmatizing beliefs about AD varied across ethnicities. More than 63% of Vietnamese associated AD with a normal process of aging, and about 10% of Chinese reported

that they would feel embarrassed if their family member had AD. Logistic regression models demonstrated that advanced age, male gender, low education, and limited English proficiency increased the odds of reporting one or multiple stigmatizing beliefs about AD. The findings suggest a varying degree of AD-related misconceptions and stigmatization and call attention to the need for culturally sensitive community education on AD in Asian communities.

#### STUDY PROTOCOL: PARTNERS AT MEALS TELEHEALTH INTERVENTION FOR CAREGIVERS OF PERSONS WITH DEMENTIA

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**Background:** As the aging population continues to increase, it is estimated that persons with dementias (PWDs) will reach 13 million by 2050. Lack of caregiver skills related to mealtime planning and the ability to cope with dysfunctional behaviors are well-documented factors that influence nutritional outcomes for PWDs, leading to social isolation, and negatively impacting their home stay. The aim of this study protocol is to test the effectiveness of a train-the-trainer program in which non-paid volunteers in respite care centers deliver a telehealth mealtime intervention for caregivers of PWDs, Partners at Meals. The program is based on the C3P Model of Changing the Place, People and Person. **Methods:** A cluster-randomized controlled trial with parallel mixed methods evaluation processes is being conducted. Caregivers and PWD dyads, receiving respite services are randomized to receive Partners at Meals or enhanced-usual-care for six months. Within the intervention group, dyads are partnered with a C3P-trained volunteer who works with caregivers to devise monthly mealtime plans. Under enhanced-usual-care, dyads receive standardized educational materials modified from The Savvy Caregiver Program for Alzheimer's caregiving. Primary outcomes include weight, calorie, protein and fluid intake of the PWDs and quality of life of the caregiver. Respite center administrators, program directors, volunteers and caregivers are evaluated for intervention fidelity, acceptability and sustainability. **Implications:** In this trial, we lay the groundwork to examine effectiveness and sustainability of a train-the-trainer telehealth program that could be widely disseminated for managing mealtimes in-the-home, while promoting quality of life of both the caregiver and PWDs.

#### TELEPHONE-BASED HEALTH COACHING: REDUCTION IN ALZHEIMER'S RISK BEHAVIORS

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**Objective:** Explore the feasibility of integrating intensive, telephone-based health coaching programs in low-income senior housing communities to reduce Alzheimer's risk behaviors. **Design:** Participants meeting study criteria: 60 years or older, a working telephone, no cognitive diagnoses, income below 1,000 USD monthly, and active cardiovascular or diabetic health symptoms were recruited from low-income

housing units. Engagement in Alzheimer's risk behaviors: Cigarette use, alcohol overuse, polypharmacy, inactivity, depression, and cognition status, were measured at enrollment, and 12 weeks post. Weekly coaching sessions focused on reducing behavioral risk for Alzheimer's disease. **Setting:** Low-income senior apartments in Richmond, Virginia **Participants:** Twenty older adults, living in low income senior high rises. Participants were majority (95%) African-American (Mean=69 years, SD=4.17, Range=61-77). **Intervention:** Participants engaged in a call with a coach for 12 weeks, focused on Alzheimer's risk reduction. Participants identified with coach specific behaviors to target. **Primary Outcome Measure:** Feasibility of telephone-based health coaching to reduce Alzheimer's Risk Behaviors. Feasibility is defined as participant engagement in health coaching and self-rated health outcomes. **Results:** Of the original 20 enrollees, 19 (95%) participated in coaching sessions. On average, 8.75 sessions were completed. All participants rated their experience as positive, and self-reported an improvement in health and healthy behaviors, in exit interviews. The coaching experience was rated 94.11 on a scale from (0-100). Participants rated their health coach, on average, 90.44 on a scale from (0-100). Participants rated their health improved as 92.37 on a scale from (0-100). **Conclusion:** Telephone-based health coaching was feasible based on participant engagement.

#### SESSION 2928 (PAPER)

##### HEALTH AND HEALTH PROMOTION I

#### COPING CAPACITY AND EPISODIC MEMORY IN OLDER ADULTS WITH SMCS: THE MEDIATING ROLE OF HEALTHY LIFESTYLE

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Older adults with subjective memory complaints (SMCs) are at increased risk for episodic memory decline. Episodic memory decline is an important predictor of objective memory impairment (one of the earliest symptoms of Alzheimer's disease) and an often-suggested criterion of successful memory aging. Therefore, it is important to explore the determinant factors that influence episodic memory in older adults with SMCs. Roy adaptation model and preliminary evidence suggest that older adults with SMCs undergo a coping and adaptation process, a process influenced by many health-related risks and protective factors. This study aimed to explore the relationship between coping capacity and episodic memory, and the mediating role of healthy lifestyle between coping capacity and episodic memory in a sample of 309 community-dwelling older adults with SMCs. Results from the structural equation modeling showed that coping capacity directly affects episodic memory ( $r=0.629$ ,  $p < 0.001$ ), and there is a partial mediating effect (60.5%) of healthy lifestyle among this sample of older adults with SMCs. This study demonstrates that coping capacity and adaptation positively correlate with episodic memory in older adults with SMCs, and that these correlations are mediated by healthy lifestyle. The results suggest that older adults with poor coping capacity should be assessed and monitored regularly, and clear lifestyle-related interventions initiated by