classes which help to build muscle, improve balance, and increase participants' confidence in fall control. A goal of the Arkansas Geriatric Workforce Enhancement Program (HRSA grant U1QHP28723) is to deliver community-based programs that improve health outcomes and quality of life. Evidence-based preventive health training is a major way to meet this goal. Two of these evidence-based trainings are Tai Chi (TC) and A Matter of Balance (AMOB), multi-week classes that help to improve balance and reduce fall risk. This study took place at scheduled community-based classes, where demographic and balance data were obtained. The aim was to determine the difference in the balance of community-dwelling OA as measured by Balance Tracking System® before and after AMOB and TC courses. Both groups showed positive changes in their mean balance percentage with the AMOB class having a higher Mean ± SD (24.3 ± 21.0) vs. the TC participants (4.0 ± 29.7). The One-Way Analysis of Variance showed statistically significant difference in the AMOB class over those in the TC class, $F(1, 32) = 5.280$, $p < 0.05$. The Cohen's $d = 0.789$ indicates a large effect between the two groups.

RACIAL DIFFERENCES IN NON-COGNITIVE SYMPTOMS IN ALZHEIMER'S DISEASE AND CAREGIVER DEPRESSION

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Behavioral and psychological symptoms (BPS) represent a heterogeneous group of non-cognitive symptoms occurring in persons with Alzheimer's disease (PwAD), and they are often associated with negative outcomes for AD caregivers. Evidence indicates differences in caregivers' mental health across race/ethnic groups. However, there is a lack of research that compares racial differences in BPS in PwAD. This study aims to compare racial differences in BPS in PwAD and caregiver depression. The study analyzed data collected from the South Carolina AD Registry in 2010. The survey used in the interview included measures of caregiver depression, caregiver burden, PwAD's non-cognitive symptoms, caregiving competence, caregiver distress, and demographics. The final analysis focused on 635 African-American (n=313) and white (n=322) caregivers. Mann-Whitney U-tests, Chi-square tests, and multiple linear regression were conducted. Among all PwAD, higher percentage of whites than African Americans exhibited apathy/indifference (67.52% vs 52.44%, p=.0001), depression/dysphoria (61.54% vs 44.59%, p<.0001), and anxiety (45.08% vs 29.64%, p<.0001). In terms of both frequency and severity of BPS, whites had significantly higher BPS score (Mean=35.49, SD=24.75) than African Americans (Mean=28.13, SD=23.97; p<.0001). Mean comparisons indicated significant group differences in caregiver depressive symptoms between white caregivers (mean=11.89, SD=6.90) and African-American caregivers (mean=9.41, SD=5.77). However, there were no racial differences in the relationship between BPS in PwAD and caregiver depression. The findings of this study highlight the importance of developing more effective and targeted treatment options and therapies for neuropsychiatric symptoms and delivering cultural relevant education programs/interventions to ethnic groups.

PEER TO PEER SUPPORT AND HEALTH CARE UTILIZATION AMONG COMMUNITY-DWELLING OLDER ADULTS

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The majority of older adults want to live and age in their communities. Some community-based organizations (CBOs) have initiated peer-to-peer support services to promote aging in place but the effectiveness of these programs is not clear. Our objective was to compare the effectiveness of a community-designed and implemented peer-to-peer support program vs. access to standard community services, in promoting health and wellness in vulnerable older adult populations. We partnered with three CBOs, one each in California, Florida, and New York, to enroll adults 65 > years of age who received peer support and matched control participants (on age, gender, and race/ethnicity) in an observational study. We followed participants over 12 months, collecting data on self-reported urgent care and emergency department visits and hospitalizations. In order to account for the lack of randomization, we used a propensity score method to compare outcomes between the two groups. We enrolled 222 older adults in the peer-to-peer group and 234 in the control group. After adjustment, we found no differences between the groups in the incidence of hospitalization, urgent and emergency department visits, and composite outcome of any health care utilization. The incidence of urgent care visits was statistically significantly greater in the standard community service group than in the peer-to-peer group. Given that the majority of older adults and their families want them to age in place, the question of how to do this is highly relevant. Peer-to-peer services may provide some benefit to older adults in regard to their health care utilization.

HOW TO STEADI YOUR PATIENTS WITH THE COORDINATED CARE PLAN TO PREVENT OLDER ADULT FALLS AND EVALUATION GUIDE

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Falls are common, costly, and the leading cause of fatal and nonfatal injuries for older Americans. Reports show that fall death rates are increasing. Healthcare providers play an important role in fall prevention but few talk to their patients about falls. This lack of communication demonstrates the need for more physician-initiated fall prevention. The Centers for Disease Control and Prevention (CDC) created the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative to help providers talk to their patients about falls. Specifically, CDC's new STEADI-based fall prevention program, the Coordinated Care Plan to Prevent Older Adult Falls (CCP) and Evaluation Guide for Older Adult Clinical Fall Prevention Programs can assist healthcare