

organizations and perform a wide range of professional and lay functions. Participant data indicate that the program has appealed to a wide variety of learners including participants who serve caregivers generally (60.8%) and grandparents raising grandchildren specifically (81%). A small majority (55.6%) of the agency-based learners reported serving, on average, more than 40 grandfamilies annually. Self-reported learning levels were notable ranging from a mean low of 3.46 out of 4 points ( $N = 157$ ,  $SD = 0.59$ ) for the volunteer recruitment and mentorship programming module to a mean high of 3.79 ( $N = 167$ ,  $SD = 0.45$ ) for the caregiver self-care module. Evaluation results from the first seven learner cohorts underscore the efficacy of program content as well as the utility of performing an initial program needs assessment to guide curriculum development. Practice implications for future continuing education efforts targeting grandfamilies professionals and lay leaders include: the need for easily accessible online education in combination with supplemental training opportunities addressing topics such as the long-term impact of substance use disorder and trauma combined with locally relevant content on grandfamilies and legal resources.

#### ASSOCIATION BETWEEN SELF-REPORTED HEALTH AND DEMENTIA SYMPTOMS AMONG PEOPLE WITH DEMENTIA AND THEIR CAREGIVERS

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People living with dementia (PwD) can often reliably self-report their health; yet, there are limited data on their and their primary caregiver's self-reported overall health (excellent, very good, good, fair, and poor). We used data from the Aging, Demographics, and Memory Study (2001-2009) to quantify the association between PwD's cognitive impairment (Mini-mental State Exam), physical limitations (scale [0-10] of activities of daily living), and behaviors (scale [0-12] of behavioral symptoms on the Neuropsychiatric Inventory Questionnaire) and self-reported health. We estimated two ordered logistic regressions estimating: 1) PwD's self-reported health (analyzed  $n=308$ ); 2) primary caregiver's self-reported health (analyzed  $n=135$ ; 173 PwD did not have primary caregiver in the survey). We controlled for the PwD demographics, chronic conditions, and if they lived in the community. The regression estimating caregiver's self-reported health also controlled for the caregiver's relationship to the PwD, and whether the caregiver lived with the PwD. PwD's self-reported health was lower (4% excellent; 16% very good; 22% good; 30% fair; 30% poor) than caregivers (14% excellent; 27% very good; 32% good; 23% fair; 4% poor). For PwD, one-additional physical limitation, but not cognition or behavior, was associated with 1.15 (95%CI: 1.01,1.30) times greater odds of self-reporting poor health compared to all other categories. For caregivers, one-additional behavior, but not cognition or physical limitations, was associated with 1.17 (95%CI: 1.01,1.37) times greater odds of self-reporting poor health. For PwD, interventions targeting physical limitations may increase self-reported health, but for caregivers, interventions targeting behavioral symptoms may increase self-reported health.

#### CAREGIVER-PROVIDER COMMUNICATION ABOUT PAIN IN PERSONS WITH DEMENTIA

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Pain in older persons with dementia (PWD) is severely under-detected and under-managed. Family caregivers can play an important role in addressing these disparities by acquiring the requisite skills to communicate PwD's pain symptoms and behaviors to health care providers, but little is known about how caregivers of dementia patients and their providers approach such pain-related discussions. We employed qualitative methods to explore the perspectives of family caregivers of PwD ( $n=18$ ) and health care providers (geriatricians, general internists, neurologists, emergency room physicians) involved in PwD's treatment ( $n=16$ ) regarding pain communication. We specifically focused on participants': 1) priorities and expectations for communicating about pain and dementia, 2) challenges to communicating about pain and dementia, and 3) strategies and recommendations for optimizing communication about pain and dementia. Analyses revealed that caregivers and health care providers expected to receive accurate, detailed information from one another, but uncertainty in both groups around differentiating pain behaviors from dementia symptoms acted as a barrier to effective information exchange. Additional challenges to productive pain-related discussions were identified by caregivers, including provider fatalism and lack of interpersonal skills, and by providers, including patient-caregiver disagreement about pain symptoms and unreliable caregiver reporting. Participants endorsed using practical approaches, such as pain scales and logs, as well as rapport-building strategies, such as affirmation of caregivers' input, to facilitate collaborative discussions.

#### CAREGIVING INTENSITY AND CAREGIVER BURDEN AMONG DEMENTIA CAREGIVERS: THE MODERATING ROLES OF SOCIAL SUPPORT

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Objective: Using the stress-coping theory, the aims of the present study were to test what levels of caregiving intensity (hours actually spent on caregiving every day) posed the most negative influence on caregiver burden as well as how social support moderated such associations among dementia caregivers. Methods: Data from the baseline assessment of the Resources for Enhancing Alzheimer's Caregiver Health (REACH II) ( $N = 637$ ) were used. Caregiver burden (12-item Zarit caregiver burden scale), caregiving intensity (caregiving hours), and social support (Lubben social network, received support, satisfaction with support, and negative interactions) were the main