

Background: Apathy affects most individuals with dementia in long-term care. Apathy assessment is fundamental for appropriate treatment. Apathy involves subjective feelings thus individual's self-evaluation may offer important perspectives for assessment. However, it is unclear whether self-evaluation is a valid assessment approach for this population. This study compared apathy ratings from resident self-evaluation to assessments from family, clinicians, and research staff. **Methods:** This pilot study enrolled 8 residents from two long-term care facilities in Pennsylvania. One family member, one certified nursing assistant (CNA), and one nurse or activity staff were also enrolled for each resident. Researchers interviewed each resident using the Apathy Evaluation Scale (AES) and rated their apathy levels. Family, CNAs, and nurses/activity staff independently rated the resident's apathy level using the AES. Direct observations were conducted by researchers using the Person-Environment Apathy Rating (PEAR). **Results:** Correlation analysis revealed a discrepancy across raters in assessing apathy. While self-evaluation and family ratings were moderately positively correlated ($r=0.48$, $p=.23$), there was a moderate correlation in the opposite direction between self-evaluation and CNA ratings ($r=-0.64$, $p=.09$). Resident self-evaluation did not correlate with nurses/activity staff ratings ($r=0.01$, $p=.99$) or researcher observations ($r=-0.08$, $p=.86$). **Discussion:** These findings may reflect residents' cognitive impairment and lack of insights, family and clinicians' lack of understanding of apathy, or nurses' and researchers' lack of acquaintance with the resident. It remains undetermined whether self-evaluation provides valid information for apathy assessment for this population. Additional research is necessary to identify the most valid assessment approach for long-term care residents with dementia.

ASKING THE PEOPLE WHO MATTER THE MOST: DESIGNING A VALUE-BASED DEMENTIA SPECIALTY CLINIC

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This presentation will highlight our research which uses a qualitative methodology to incorporate the voices and experiences of people impacted by dementia into the value-based health model. This model is characterized by a team-based approach as well as the measurement of outcomes. The aim of value-based care is to provide individuals meaningful and compassionate care that helps them achieve the health outcomes that matter most to them. Foundational to creating this person-centered model is the incorporation of the perspectives of individuals with dementia and their care partners. Experience Groups offer an opportunity for those affected by dementia to share their expertise and describe their daily challenges and successes so we are able to learn from their experiences and better understand unmet and unarticulated needs. The findings of this research—consisting of 41 patients and 11 care partners—enabled the development of outcome measurement tools implemented at the clinical level, and the design of a care delivery model that addresses unmet needs. Some of the key findings from the research that

have been implemented at the Cognitive Disorders Clinic and that will be highlighted in this poster are: 1. Care partners would like more emotional support from their medical team; 2. Individuals want more information about the trajectory of the disease and an actionable “roadmap-of-care”; 3. Care partners and those with early stage memory loss desire counseling and team-based care versus strictly physician-provided care.

ALZHEIMER'S DISEASE AND RELATED DEMENTIAS IN MEXICAN AMERICAN MEDICARE BENEFICIARIES

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Objective: To determine the prevalence and incidence of Alzheimer's Disease and Related Dementias (ADRD), and to identify the socio-demographic and health characteristics of Mexican-American older adults with ADRD. **Methods:** Data are from wave 5 (2004/05) of the Hispanic Established Population for the Epidemiological Study of the Elderly linked with Centers for Medicare and Medicaid Services files. We studied 1166 participants of which 927 did not have an ADRD diagnosis before wave 5 interview and followed until 2016. Measures included socio-demographics, medical conditions, depression, physical function, Mini-Mental-State- Examination (MMSE), body mass index (BMI), disability, and ICD-9-CM codes for ADRD. **Results:** A total of 424 participants had an index diagnosis of ADRD during 11-years. The total prevalence rate ranged from 31.6% in 2006 to 72.8% in 2016, and the total incidence rate ranged from 9.3% in 2006 to 15.8% in 2016. The prevalence rate ranged from 30.3% to 69.7% in men and 32.5% to 74.1% in women. The incidence rate ranged from 8.5% to 12.9% in men and 9.8% to 12.9% in women. Those with ADRD were significantly more likely to be older (82.1 versus 81.6 years; $p\text{-value}=0.024$) and to have a lower score in the MMSE (21.1 versus 21.7; $p\text{-value}=0.013$) compared with whole sample ($N=927$). Non-significant differences were observed by sex, education, medical conditions, BMI, depression, physical function or disability compared with whole sample. **Conclusions:** The prevalence and incidence rates of ADRD in Mexican-American Beneficiaries is high. These findings underscore the need for clinical services and caregiving resources in this population.

PROTECTIVE EFFECT OF LIFETIME EXPERIENCES ON FUNCTIONAL STATUS IN YOUNG-ONSET DEMENTIA

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Patients with Frontotemporal degeneration (FTD), a common form of young-onset dementia, experience decline in cognitive, social and daily functioning as the disease progresses. Research shows that lifestyle factors may be an important modifiable risk factor for dementia, but this has not been well studied in FTD. In this study, we test the hypothesis that lifetime experiences, including