

points (2011 to 2013: $B=.06, SE=.01, p<.0001$; 2013 to 2015: $B=.05, SE=.01, p<.0001$), and life satisfaction also positively predicted sleep duration across timepoints (2011 to 2013: $B=.07, SE=.01, p<.0001$; 2013 to 2015: $B=.03, SE=.01, p<.05$). These associations remained unchanged when taking demographics, and noontime napping into account. The findings indicate that the relationship between life satisfaction and sleep duration is bidirectional. Sleep duration may present as a mechanism for the relationship between life satisfaction and health, and suggests that effective treatment of sleep duration may improve life satisfaction.

T3:T4 RATIO CAN DISTINGUISH BETWEEN ADAPTIVE CHANGES AND TRUE SUBCLINICAL HYPOTHYROIDISM IN OLDER ADULTS

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Because of heterogeneity in hormonal aging,¹ we believe isolated elevated TSH is insufficient to drive clinical decision making for thyroid hormone replacement in older adults. We performed a cross-sectional study involving 63 older adult participants of the BLSA in order to assess the diagnostic value of individual hormone levels or free T3: free T4 ratio for differentiating thyroid-aging phenotypes. We defined two phenotypic groups, central adaptation and primary hypothyroidism, both with a rising TSH and with a rising or falling FT4 respectively. Fifty-four percent of study participants were male, the average age was 78.8 years, and 66.7% had the primary hypothyroidism phenotype. The unadjusted odds ratio of having the central adaptation phenotype is 23.40 (95% CI 3.66-149.73) for every unit increase in the FT3:FT4 ratio. The ROC curve had a C-statistic of 0.815. Similarly, FT4 alone distinguished the phenotypes with a C-statistic of 0.864. In contrast, TSH and FT3 were not predictive (C-statistic of 0.617, and 0.479 respectively). When the analysis is limited to the 24 individuals with elevated TSH, the ratio remains predictive (0.839). Both the higher FT4 and the lower ratio found in individuals with adaptive changes are consistent with a physiology similar to the adaptations seen in acute illness. This supports the hypothesis that elevated TSH can represent a response to stressors with aging and doesn't always warrant treatment with thyroid hormone. Our findings suggest that full thyroid function panel can be used to make better diagnostic decisions in older adults.

WEIGHT LOSS MOTIVATION IN OLDER PRE-DIABETICS: PRELIMINARY EVIDENCE BY RACE IN THE EGGSPDITE STUDY

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Obesity hastens functional decline and intensifies chronic health conditions among older adults. Late-life obesity is of

particular concern for older African Americans, who are at increased risk for obesity and type 2 diabetes and for whom weight loss interventions can be less effective. However, obesity interventions have been under-studied in this population; little is known about potential differences in motivation for change by race. The ongoing Eggs PreDiabetes Intervention Trial (EGGSPDITE) is a randomized controlled trial of expedited weight loss in older (60+ years) Black and White adults with prediabetes. Participants completed both the Stages- and Processes of Change questionnaires in Weight Management (S-Weight and P-Weight) at baseline and end of 4-month intervention. Preliminary combined-group analysis indicates that, while White participants reported a higher average stage of change at baseline, there was no difference by race ($p < 0.05$) in changes for body weight, fat mass, and hemoglobin A1c at endpoint. Reductions in weight consequences evaluation (WCE) and increases in weight management actions (WMA) subscales were observed in both races ($p < 0.05$), with a trend toward decreased emotional re-evaluation (EmR; $p = 0.06$). Of the processes of change subscales, only WCE differed by race ($p < 0.05$), with White participants showing $\approx 13.5\%$ higher utilization, relative to Black participants, at both time points. These preliminary findings suggest that weight loss interventions can be equally effective among black and white older adults, although motivations for weight loss may differ by race.

WHAT ACCOUNTS FOR PHYSICAL AND EMOTIONAL HEALTH? INFLUENCE OF HEALTH, PERSONALITY, AND HEALTH ACTIVATION

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The purpose of this study was to identify associations among health personality, health activation, and emotional and physical health, and to identify direct and indirect effects. Participants in the study consisted of 3907 older adults, 65 years of age and older. Measures used in the analyses were the Health Personality Assessment, the Consumer Health Activation Index, and The Veterans RAND 12-Item Health Survey. Structural equation modeling with bootstrap sampling estimation was conducted to examine direct and indirect effects. The measurement model, $X^2(307)=2142.34$, CFI=0.96, RMSEA=0.04, and structural model, $X^2(313)=2167.36$, CFI=0.96, RMSEA=0.04 yielded an acceptable fit. Significant direct paths were observed between health personality factors and health activation, and in turn health activation to emotional and physical health. The results indicate that older adults with lower levels of Health Neuroticism, lower Health Openness, higher Health Agreeableness, and higher Health Conscientiousness had higher levels of health activation. In addition, older adults with higher levels of health activation had higher emotional and physical health. Also, direct paths from health personality to emotional and physical health were observed. Lastly, significant indirect effects were health activation had a significant positive indirect effect on physical health through Health Agreeableness. Health activation had a significant negative indirect effect on emotional health through Health Neuroticism and Health Openness. The implication of this study is that health activation has a significant role in the emotional and physical health of older adults