

SESSION 1005 (SYMPOSIUM)

INTEREST GROUP SESSION—BEHAVIORAL INTERVENTIONS FOR OLDER ADULTS: ADDRESSING CLINICAL SYMPTOMS OF DEMENTIA: PRELIMINARY RESULTS FROM DEMENTIA BEHAVIOR TRIAL

Chair: Katherine A. Marx, *Johns Hopkins University, Baltimore, Maryland, United States*

Co-Chair: Laura N. Gitlin, *Drexel University, Philadelphia, Pennsylvania, United States*

Discussant: Joseph E. Gaugler, *University of Minnesota - School of Public Health, Division of Health Policy and Management, Minneapolis, Minnesota, United States*

Currently, just under six million people living in America are diagnosed with Alzheimer's disease or related dementia. Most people with dementia live in a community setting and are cared for by a family member. Persons living with dementia almost universally experience behavioral and psychological symptoms (BPSD), such as agitation, aggression, and rejection of care as well as functional dependence. These symptoms are related to negative outcomes for both the person living with dementia and the family caregiver. Prior research shows that nonpharmacologic interventions such as meaningful activities, education, and multicomponent interventions have promise in managing behaviors. This symposium focuses on preliminary outcomes from the Dementia Behavior Study (DBS), a Randomized Control study that examined the effect of the Tailored Activity Program (TAP) in a community setting on BPSD and functional dependence in persons living with dementia, and caregiver wellbeing (e.g. depression, burden, perceived change). Gitlin et al will present outcomes of the primary aim (BPSD) and secondary aims (functional dependence and caregiver wellbeing) of the DBS. Pizzi et al explore the cost analysis of the TAP intervention versus the active control group. Scerpella et al describe the alerts and adverse events that were associated with the DBS. Marx et al present the relationship between race and caregiver readiness to participate in TAP. Regier et al explore the BPSD Rejection of Care and the association to caregiver burden. Tailoring interventions, such as activities may improve quality of life for both the person with dementia and the family caregiver.

FAMILY CAREGIVER READINESS: RACIAL DIFFERENCES AND RELIABILITY OF THE CAREGIVER READINESS SCALE

Katherine A. Marx,¹ Katherine A. Marx,¹ Lauren J. Parker,¹ Jin Huang,¹ and Daniel Scerpella,¹ Karen Rose,² Catherine V. Piersol,³ and Laura N. Gitlin⁴, 1. *Johns Hopkins University, Baltimore, Maryland, United States*, 2. *Widener University, Chester, Pennsylvania, United States*, 3. *Thomas Jefferson University, Philadelphia, Pennsylvania, United States*, 4. *Drexel University, Philadelphia, Pennsylvania, United States*

The success of any intervention for caregivers of persons with dementia is dependent on the caregiver's readiness to enact the strategies. This presentation explores the reliability of the new 17-item Caregiver Readiness Scale (CRS) and also to examine the differences by race in readiness. Participants were caregivers in the Dementia Behavior Study who

completed the CRS at baseline (n=129). Caregivers were on average 65.8 years old (sd = 12.2, range 28-88), the majority reported their race as non-Hispanic white (64.3%, n=83) and 33.4% (n=43) reported their race as African American or other. The average CRS score was 57.63 (sd=5.72, 40-68) ($\alpha=0.73$). The only significant interaction with race was negative communication (p=0.026) with negative communication scores having little effect on readiness in whites, but in non-white caregivers, there was an inverse relationship. Knowing the caregiver's level of readiness and communication style may help improve the acceptability and success of an intervention.

ADDRESSING DEMENTIA CLINICAL SYMPTOMS USING NONPHARMACOLOGICAL STRATEGIES: WHAT WORKS AND FOR WHOM?

Laura N. Gitlin,¹ Laura N. Gitlin,¹ Katherine A. Marx,² Catherine Verrier Piersol,³ Nancy A. Hodgson,⁴ Jin Huang,² David Roth,² and Constantine G. Lyketsos⁵, 1. *Drexel University, Philadelphia, Pennsylvania, United States*, 2. *Johns Hopkins University, Baltimore, Maryland, United States*, 3. *Thomas Jefferson University, Philadelphia, Pennsylvania, United States*, 4. *University of Pennsylvania, Philadelphia, Pennsylvania, United States*, 5. *Johns Hopkins Bayview, Baltimore, Maryland, United States*

People living with dementia experience behavioral symptoms and functional decline and their caregivers (CG), reduced wellbeing. In an RCT (N=250 dyads), we tested whether tailoring activities to interests/abilities and providing CGs with instruction in their use (Tailored Activity Program, TAP) reduced clinically significant agitation/aggression (main outcome), functional decline and improved CG wellbeing (secondary outcomes) compared to CG education/support alone; with both groups receiving 8-sessions over 3-months. At 3-months, TAP had no effects on agitation/aggression compared to CG education/support but reduced functional decline (p=0.03), improved CG wellbeing (p=0.01) and confidence using activities (p=0.02). In secondary analyses, black vs. white CGs reported reduced agitation/aggression (p=0.01); female CGs reported reduced burden with TAP whereas male CGs reported reduced burden from education/support (p=0.04); spouses vs. non-spouses reported slower functional decline in participants (p=0.01). This trial suggests outcomes vary by subgroups. Different nonpharmacological approaches are needed for specific clinical characteristics: one size will not fit all.

TAILORED ACTIVITY PROGRAM (TAP) COSTS: OPPORTUNITIES TO STREAMLINE DELIVERY AND PURSUE REIMBURSEMENT

Laura T. Pizzi,¹ Laura T. Pizzi,¹ Katherine M. Prioli,¹ Eric Jutkowitz,² Jing Yuan,¹ and Laura N. Gitlin³, 1. *Rutgers University, Piscataway, New Jersey, United States*, 2. *Brown University, Providence, Rhode Island, United States*, 3. *Drexel University, Philadelphia, Pennsylvania, United States*

TAP intervention costs captured alongside the randomized controlled study included labor of program staff, mileage, supplies and materials. Staff time costs were converted to \$US 2017 by multiplying hours spent by the appropriate wage rate plus fringe benefits; mileage was costed using the federal reimbursement rate. Research costs were excluded to