

were positively associated with AD completion. Physical and mental health needs were not significantly associated with AD completion. This is among the first studies focusing on AD completion among Chinese Americans, one of the fastest growing older minority populations in the US. Findings highlight the influence of socioeconomic and cultural factors on AD completion and illustrates the importance of developing culturally sensitive interventions to promote end-of-life care decision-making among older Chinese Americans.

DISPARITIES IN EOL CARE BY DEMENTIA STATUS AND RACE

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Prior research shows that minority and dementia status are associated with suboptimal end-of-life (EOL) care quality; care that is more aggressive, invasive, and futile. We conducted a retrospective study of EOL care for 300 decedents of varied race/ethnicity in a skilled nursing facility. The purpose of this secondary analysis was to test whether the EOL experience (medical orders in place, treatments, distressing symptoms, discussions with providers) differed by dementia status for different race/ethnic groups (Black, White, Hispanic). Chi-square tests were used to examine the relation between these four sets of EOL variables and dementia status (yes/no) separately for the three groups. Findings showed that for White decedents, PWD were less likely to have had a DNR or a DNI discussion with a provider in the nursing home. Also for White decedents, PWD were less likely to have had shortness of breath or pain. For Black decedents, PWD were more likely to have a DNR order. Also, for Black decedents, PWD were less likely to have been hospitalized. For Hispanic decedents, EOL variables and dementia status were not significantly associated. Overall, findings showed differences by race/ethnic groups in EOL experience based on dementia status. Black decedents with dementia were more likely to have escaped the acute care default. Findings for White decedents with dementia were mixed for aggressive versus comfort care. The EOL experience did not differ by dementia status for Hispanic decedents. Thus, efforts to promote positive EOL care for persons with dementia need to account for differences by race/ethnicity.

UNRAVELING THE EFFECTS OF SOCIAL CLASS AND SYSTEMIC RACISM ON ADVANCE CARE PLANNING

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While advance care planning (ACP) is recognized as a key facilitator of high-quality, goal-concordant end-of-life care, black Americans are less likely to participate in ACP than non-Hispanic whites (Carr 2011; Detering et al. 2010). There are divided explanations for why these disparities persist. Some scholars attribute racial disparities in end-of-life care to socioeconomic (SES) differences between black and white Americans citing blacks' and whites' differentiated access to, control over, and use of material resources (Wilson 1978; Yearby 2011). Others assert that health care preferences do not solely reflect lack of resources or health literacy, but that the larger social context frames care preferences differently across racial and ethnic groups in American society (Alegria et al. 2011; Sewell and Pingel forthcoming). By turning the analytical lens to class-privileged black

Americans, I investigate whether racism overflows the margins of class disadvantage. Using data from the Health and Retirement Study, I ran logistic regression and moderation models. I found that class-privileged blacks are less likely to engage in ACP than both high-SES and low-SES whites. The interaction of race and SES was negatively and significantly associated with ACP (OR=0.91; P<0.05), indicating that SES has a stronger effect on the probability of ACP among whites than among blacks. Predicted probabilities show that 51% of low-SES whites are likely to engage in ACP compared to 32% of high-SES blacks. These findings indicate that racialized disparities in ACP exist independent of SES, and that the effects of SES and race are intersectional rather than simply additive.

WHEN CANCER MEETS DEMENTIA: THE END-OF-LIFE CAREGIVING EXPERIENCE FOR OLDER ADULTS WITH COMORBID DEMENTIA AND CANCER

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Older adults with comorbid dementia and cancer is an increasing phenomenon with the aging population worldwide. Caregivers of these older adults might have a totally different and unique end-of-life caregiving experience. This is because all physical and behavioral signs and symptoms of dementia and cancer may interact with each other and complicate the caregiving experience. The aims of this study was to understand and examine the end-of-life caregiving experiences for older adults with comorbid dementia and terminal cancer from the perspective of family caregivers. Twenty-one caregivers were invited to participate in a semi-structured interview that examined the end-of-life caregiving experiences, its impact and how they coped with the challenges they faced. The interviews were transcribed and analyzed using interpretative phenomenological analysis. The essential meaning of the phenomenon is understood as "grieving thrice, suffering dually and becoming one", characterized by how caregivers understood the meaning of togetherness after going through the time of recurring losses from dementia through cancer to death and experiencing ambiguous sufferings dually with their loved one. Ambiguous sufferings were not "there" before the diagnosis of cancer but emerge in the context of comorbid dementia and cancer and in the connection with the caregivers making interpretation and appraisal of their internal and external resources. These important findings fill in the knowledge gap in the literature related to end-of-life caregiving experience for older adults with comorbid dementia and cancer; and may guide the development of appropriate interventions to support the older adults and their caregivers in a holistic approach.

SESSION 2990 (PAPER)

RISK OF MILD COGNITIVE IMPAIRMENT AND DEMENTIA

DECREASING SOCIAL SUPPORT ASSOCIATED WITH RISK OF MCI AND DEMENTIA IS PARTIALLY MEDIATED BY HIPPOCAMPAL VOLUME

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Less supportive social relationships are linked to greater risk of cognitive decline in older adulthood. Few studies have examined if declines in social support predict risk of developing Mild Cognitive Impairment (MCI) or dementia and the neurobiological factors that may contribute to these associations. We analyzed data from 926 women in the Women's Health Initiative Memory Study-MRI (WHIMS-MRI) to examine whether low social support at baseline and declines over an 8-year period predicted subsequent risk of developing MCI/dementia. Social support (Medical Outcomes Study Social Support Scale) was self-reported at the baseline (1994-1998) and closeout (2004-2005) of the parent WHI hormone therapy clinical trial. Annual neuropsychological assessments were conducted in WHIMS (through 2018) to ascertain incident MCI/dementia; structural brain scans were performed in 2005-2006. Structural equation models assessed the association between level and change in social support and risk of incident MCI/dementia and putative mediation of these associations by structural brain variables in women free of MCI/dementia as of the trial closeout, adjusting for demographic, lifestyle, depression, and biomedical covariates. Both low baseline social support (HR=1.24 per 1-SD; $p < .05$) and declines in support (HR=1.18 per 1-SD; $p < .05$) predicted incident MCI/dementia risk. Women reporting decreasing social support had significantly lower hippocampal volumes ($\beta = -.070$; $p < .05$) which accounted for ~14% of the total effect of declining support on MCI/dementia risk. We will highlight the implications of these findings for understanding how changes in social support may be linked to risk of MCI/dementia, including potential bidirectional associations of changes in social support and neurobiological health.

LANGUAGE AND MEMORY RESERVE MEDIATE PROTECTIVE EFFECTS OF SOCIAL SUPPORT ON MCI OR DEMENTIA RISK IN OLDER WOMEN

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More supportive social relationships are protective of cognitive decline in older adulthood. Although supportive social relationships are hypothesized to promote cognitive reserve (CR; the cognitive adaptation to neuropathology), it is unknown whether CR mediates associations between social support and risk of developing mild cognitive impairment or dementia (MCI/dementia). Data from 815 women (aged 73-87 years) participating in the Women's Health Initiative Memory Study-MRI cohort (WHIMS-MRI) and Women's Health Initiative Study of Cognitive Aging (WHISCA) were

analyzed to examine whether domain-specific estimates of CR mediate associations between social support and incident MCI/dementia risk. Women completed the Medical Outcomes Study Social Support Scale (MOS-SS) in 2004-2005, a structural MRI (sMRI) of the brain in 2005-06, and annual extensive neuropsychological examinations till 2018. CR (6-months after completing the MOS-SS) was estimated across different domains (e.g. verbal memory, figural memory, language, visuospatial, and attention) as the residual variance after regressing out effects of sMRI variables, sociodemographic factors, and measurement error. Structural equation models were constructed to examine whether CR mediate associations between social support and MCI/dementia risk while adjusting for covariates. Higher social support was associated with lower MCI/dementia risk (hazard ratio=0.85 per 1-SD; $p = 0.037$), higher language reserve (standardized $\beta = 0.09$; $p = 0.008$) and verbal memory reserve (standardized $\beta = 0.08$; $p = 0.025$). Language and verbal memory reserve each significantly explained approximately 14% of the protective effect of social support. Findings illustrate the heterogeneous effect of social support on CR, highlighting the importance of language and verbal memory reserve as mediators of the association between social support and MCI/dementia risk.

SOCIAL INTEGRATION AND RISK OF DEMENTIA AMONG OLDER ADULTS

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We examine the relationship between social integration and cognitive impairment and dementia among older adults using longitudinal data from Waves 1-8 of the National Health and Aging Trends Study (NHATS). The sample includes 7,492 respondents age 65 and older at baseline. We test multidimensional measures of social integration and cognitive well-being using discrete-time hazard models. The risk of dementia is calculated by a series of performance-based tests. Measures include levels of dementia: no dementia, cognitive impairment not dementia (CIND), and dementia, and three domains of cognition functioning: orientation, executive function, and memory. Social integration is an additive index measured by several questions, including marital status, living arrangement, social network, social contact, and social participation. Our results indicate that people with higher social integration have a lower risk of both cognitive impairment (not dementia) and dementia compared to those with lower social integration. This pattern continued across specific domains of cognitive functioning, including lower risk of orientation impairment, executive function impairment, and memory impairment for those with higher social integration. Tests of both gender and racial interactions did not yield any significant differences. Our findings demonstrate the strong association between social integration and lower risk of dementia among older adults. This study can speak to policy makers as the life expectancy of Americans increases and the aging population grows, highlighting the importance of giving support to older adults who are lack of social connectedness.