

rural context. However, dementia and cognitive impairment are more prevalent among rural older adults than urban older adults. This presentation has two objectives: to examine cognitive health promotion from the perspective of rural older adults; and 2) to identify key activities associated with ameliorating cognitive decline in rural communities. Drawing on a community-based participatory research approach, data was collected through two waves of semi-structured interviews with the same group of 42 older adults in rural Saskatchewan, Canada. Guided by lay theory and cultural schema theory, data was coded using thematic analysis. In describing cognitive health promotion, four key areas emerged including emotional health, intellectual health, social health, and functional health. In discussing activities to support cognitive health promotion, participants emphasized the importance of thinking positively, keeping your brain active, mingling with others, and managing your daily affairs. Focusing on older adults' perceptions of cognitive health promotion provides valuable information to advance knowledge of key strategies and activities to support cognitive health. In developing effective strategies to promote cognitive health, it is essential to engage in collaborative research and partnerships with older adults.

PREDICTORS OF ATTRITION IN THE MULTI-ETHNIC 1FLORIDA ADRC CLINICAL CORE

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Understanding predictors of attrition can position researchers to increase retention efforts and focus on preventing attrition. Attrition, or dropout of participants during a study prior to completion, can threaten the internal and external validity of a study's findings. Data from the 1FloridaADRC Clinical Core was analyzed, and included 271 participants within a two-year follow-up window, of which 216 (79.7%) were retained. T-tests and chi-square analyses were used to determine if a number of demographic, clinical, acculturation, and neuroimaging predictors were associated with attrition. The participant cohort included: 85% with cognitive impairment; 60% Hispanic; 42% over the age of 75; and 62% female. Predictors of greater attrition included: age over 75 years ($p < .003$); cognitive diagnosis of MCI or dementia ($p < .01$); and lower scores on the Mini-Mental Status Exam ($p < .04$), the Hopkins Verbal Learning Test (HVLT) immediate ($p < .02$), and delayed ($p < .002$) Higher total score on the Neuropsychiatric Inventory Questionnaire ($p < .06$), endorsement of night time behaviors ($p < .05$) and greater hippocampal atrophy ($p < .02$) were also predictive of attrition. Hispanic ethnicity was not a predictor of attrition, as retention was 81% for Hispanics versus 79% for non-Hispanics. However, among Hispanic participants, English acculturation measured by the Bidimensional Acculturation Scale for Hispanics was lower for those who dropped out ($t = 2.8$; $p = .006$).

PREDICTORS OF INSOMNIA IN INDIVIDUALS WITH MILD COGNITIVE IMPAIRMENT

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Insomnia is a common disorder that affects up to 40% of people age 65 and older. Untreated insomnia can decrease quality of life, increase healthcare use, and exacerbate cognitive problems. Individuals with cognitive impairment experience more sleep disorders than those without cognitive concerns, yet little is known about insomnia and mild cognitive impairment (MCI). Our objective was to examine predictors of insomnia in persons with MCI (PwMCI). Using data from the National Alzheimer's Coordinating Center Uniform Data Set, a cross-sectional study of older PwMCI was conducted. Independent sample t-tests and contingency tables with chi-square tests of independence were used to examine differences between PwMCI with and without insomnia. Multivariate binary logistic modeling was performed. The total sample ($N = 1543$) was comprised of 234 (15.1%) with clinician-reported insomnia and 1309 (84.9%) without insomnia. PwMCI and insomnia were more likely to be younger, take more medications, and smoke cigarettes ($p < .05$). Three variables significantly predicted insomnia in PwMCI subjects in a multivariate model: active depression (OR 1.66, 95%CI 1.21, 2.27), active anxiety (OR 2.16, 95%CI 1.57, 2.99) and arthritis (OR 1.78, 95%CI 1.33, 2.39). Differences in predictors of insomnia in PwMCI highlight the need for geriatric and mental health specialists to provide specialized care to this population. Future studies should examine conversion of PwMCI with insomnia to dementia and the compounding effects of insomnia on cognition.

AGE AND ADVANCE CARE PLANNING PREDICTS SELF-PERCEIVED RISK FOR DEMENTIA

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Self-perceived Alzheimer's disease and related disorders (ADRD) risk may be highly influenced by the sense of control which one has over the prevention and negative impact of such diagnoses (Kessler et al., 2012). This study examined whether age, advance care planning (ACP), and experimentally manipulated dementia salience (DS) are related to self-perceived risk of dementia. Participants ($N = 122$, 40 to 88 years old, $M = 65.66$, $SD = 9.71$) completed the computerized study using Qualtrics software. Participants completed questionnaires assessing individual differences, self-perceived risk, and demographics. Multiple regression was calculated to predict self-perceived ADRD risk based on age, ACP, and DS induction. The set of predictors explained 15.3% of variance in participants' self-perceived risk of dementia, $F(3, 118) = 7.08$, $p < 0.001$. Specifically, being older ($\beta = -0.40$, $p < 0.001$) and having less ACP items completed ($\beta = 0.26$, $p < 0.01$) uniquely predicted lower perceived risk. DS condition ($\beta = -0.01$) did not attain significance in the model. Younger age might be associated with less ADRD exposure and understanding, which may influence perceived risk. It is possible that older adults are less worried about developing dementia as they may (erroneously) believe they have "passed" the time to develop ADRD. Additionally,