Assessment; MoCA) and PROMIS-29 Profile (physical functioning, anxiety, depression, fatigue, sleep disturbance, social functioning, pain). Analyses examined differences by age and MoCA in: 1)Level—correlations, multivariable regressions controlling for disease severity (UPDRSmotor, PD duration), comorbidity (CIRS-G), demographics; 2) Reliability--Cronbach's alpha, and 3)Validity--correlations of PROMIS physical function with physician assessments. Sample was age M=68.0(SD=9.1); range=36-93 years, 64% male, 87% white, 37% college educated, PD duration M=8.2(SD=6.1) years, and MoCA M=24.3(SD=4.9; range 2-30). Greater cognitive impairment was consistently associated with greater physical/mental impairment (r=.14-.45; p<.05), except for sleep disturbance (r=-.07, p=.08) Multivariable regressions found cognition remained a significant predictor of physical functioning, anxiety, and depression older age predicted anxiety and social functioning. Comorbidity was the greatest predictor across all the PROMs (r=.22-.45). Reliability for PROMIS measures was excellent (alpha>.8) across cognitive and age groups, except for Fatigue at MoCA.36) across cognition and age groups. Cognitive impairment in PD is associated with lower physical function and mental health levels. Reliability and validity of most PROMs in PD are neither impacted by cognition nor age.

INCIDENT COGNITIVE IMPAIRMENT DURING AGING IN RURAL SOUTH AFRICA: EVIDENCE FROM THE HAALSI COHORT, 2014 TO 2019

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We estimated the incidence of cognitive impairment and its key sociodemographic, social, and health-related predictors at the first longitudinal follow-up of the population-representative "Health and Aging in Africa: A Longitudinal Study of an INDEPTH Community in South Africa" (HAALSI) cohort of adults aged ≥40 in rural Agincourt, South Africa. Cognitive impairment was defined as scoring ≥1.5 SD below the baseline mean composite time orientation and episodic memory score, or requiring a proxy interview with "fair" or "poor" proxy-reported memory. Activity of daily living (ADL) limitations were compared according to incident cognitive impairment status. Incidence rates (IRs) and rate ratios (IRRs) for cognitive impairment according to sociodemographic, social, and health-related predictors were estimated using Poisson regression with robust standard errors, and weighted to account for mortality. Over a 3.7-year mean follow-up, 309/3,861 at-risk participants newly developed cognitive impairment (IR=24.0/1000 person-years (PY); 95% CI: 21.6-26.8). Incidence increased from IR=9.1/1000 PY (95% CI: 5.5-16.1) among those aged 40-44 at baseline to IR=76.5/1000 PY (95% CI: 63.2-93.4) among those aged 80+. At least one ADL limitation was prevalent in 39% of those with incident cognitive impairment, compared to 7% of non-impaired participants. Incident cognitive impairment did not vary by sex/gender, HIV status, or cardiovascular factors, but was strongly graded according to education, literacy, household assets, employment, marital status, and frequency of alcohol consumption. This study presents one of the first incidence rate estimates for cognitive impairment in sub-Saharan Africa. Social disparities in cognitive impairment were apparent in patterns similar to many high-income countries.

LOW COGNITIVE FUNCTION IS ASSOCIATED WITH REDUCED FUNCTIONAL FITNESS AMONG COMMUNITY-DWELLING OLDER ADULTS

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Among older adults over 70, 22-30% report difficulty performing at least one activity of daily living (ADL). While the precipitants of ADL decline are multifactorial, over 50% of cognitively impaired adults require assistance with ADLs. The exact relationship between cognitive and functional decline remains unknown, but it is important to understand their relationship. Eighty-three older adults (80.9 + 5.4 years) enrolled in this study and completed functional fitness and cognitive assessments. Functional fitness assessments included: Short Physical Performance Battery (SPPB), 10-meter walk, dual-task, and power chair stand (average and peak). Cognition was assessed using the Montreal Cognitive Assessment (MoCA) and Visual Paired Comparison task (VPC). Categories of low cognitive function (LCF) and high cognitive function (HCF) were determined by VPC scores. SPPB was 10.2% greater among the HCF group. The HCF group walked 12.6% (0.16 m/s) faster than the LCF group. Dual-task (fast) performance was 13.2% faster among the HCF group. Additionally, when rising from a seated position during the average and peak power chair stand task, the HCF group moved 16.7% and 16.1% faster than the LCF group, respectively. MoCA scores were 2.8 points greater among the HCF group. Based on the current results, significant differences exist between cognitive groups suggesting a relationship between functional fitness and cognition. What remains unknown is the ability to influence functional fitness by changing cognition or vice versa. Future research is warranted to determine the relationship of change in either domain over time.

PROMOTING CONVERSATIONS ABOUT COGNITIVE DECLINE BETWEEN OLDER ADULTS AND PRIMARY CARE PROVIDERS

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