These challenging circumstances have driven caregivers to quickly adapt as they continue to manage their personal lives and caregiving responsibilities. Utilizing three waves of survey data from the MIT AgeLab Caregiver Panel, this presentation will examine the attitudes, experiences and worries of family caregivers at several time points along the course of the COVID-19 pandemic, as well as caregivers' preparations and coping behaviors along the way. Differences between caregiving situations will also be discussed.

Session 2195 (Paper)

Chronic Disease Management (HS Paper)

ENERGY DECLINE MAY PREDICT MILD PARKINSONIAN SIGNS IN COMMUNITY-DWELLING OLDER ADULTS

Rebecca Ehrenkranz,[1] Qu Tian,[2] Andrea Rosso,[3] Nancy W. Glynn,[4] Lana Chahine,[3] James Hengenius,[3] Xiaonan Zhu,[3] and Caterina Rosano,[3] *1. University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, United States, 2. National Institute on Aging, Baltimore, Maryland, United States, 3. University of Pittsburgh, Pittsburgh, Pennsylvania, United States, 4. University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, United States*

Mild Parkinsonian Signs (MPS) are common in older adults without overt neurological disease. MPS are often progressive and predict disability and dementia, yet little is known about predictors for MPS. Low self-reported energy is associated with mobility impairment, which is a hallmark of MPS. Yet whether self-reported energy relates to MPS is unknown. We explored the association of changes in self-reported energy with MPS in 293 participants (aged 83 ± 2.8 years, 58% women, 61% White) free of dementia and Parkinson's Disease in the Health, Aging and Body Composition Study. Self-reported energy was assessed on a 0-10 scale annually between Year 2 and Year 10 (mean follow-up: 8 years) and its slope was estimated via linear mixed effects models. MPS were evaluated at Year 10 based on the Unified Parkinson Disease Rating Scale motor component. On average, self-reported energy declined 0.06 points per year. In a linear regression model adjusted for age, fatigue, and comorbidities, those with MPS had steeper SEL decline (β [Standard Error] = -0.358 [0.119]) in the prior eight years than those without MPS. Thus, declining self-reported energy may be a risk factor for MPS. Self-reported energy is easily evaluated in routine clinic visits, and may be a modifiable risk factor that can be targeted to reduce the incidence of MPS.

HEALTHY LIFESTYLE AND SOCIAL NETWORK PROLONG DISABILITY-FREE SURVIVAL IN OLDER ADULTS WITH DIABETES

Ying Shang,[1] Wei Wu,[2] Abigail Dove,[1] Jie Guo,[1] Anna-Karin Welmer,[3] Debora Rizzuto,[1] Laura Fratiglioni,[3] and Weili Xu,[1] *1. Karolinska Institutet, Solna, Stockholms Lan, Sweden, 2. Hubei University of Chinese Medicine, Hubei University of Chinese Medicine, Hubei, China (People's Republic), 3. Karolinska Institutet 17175, Stockholms Lan, Sweden*

Aim: We aimed to estimate the extent to which diabetes shortens disability-free survival, and identify which factors may prolong disability-free survival in older adults with diabetes. Methods: A total of 2,216 disability-free participants aged ≥60 were followed up to 15 years. Diabetes was ascertained through antidiabetic drug use, medical records, or HbA1c ≥ 6.5%. Disability-free survival was defined as the survival until the occurrence of disability. Data on behaviours (healthy vs. unhealthy), leisure activities (active vs. inactive), and social network (moderate-to-rich vs. poor) were collected at baseline. A favourable (vs. unfavourable) lifestyle profile was defined as the presence of at least one of healthy behaviours, active engagement in leisure activities, and/or moderate-to-rich social network. Data were analysed with Cox regression and Laplace regression. Results: During the follow-up, 1,345 (60.7%) participants developed disability/death. Diabetes was related to the outcome (HR 1.29, 95% CI 1.06–1.57), and shortened 2.15 (1.02–3.27) years of median disability-free survival. Additionally, disability-free survival (95% CI) was shortened by 3.29 (1.21–5.36), 3.92 (2.08–5.76) and 1.66 (0.06–3.28) years for participants with diabetes plus unhealthy behaviours, inactive leisure activities, or poor social network, respectively (reference: no diabetes plus healthy behaviours, leisure activities, or moderate-to-rich social network). Among participants with diabetes, a favourable profile led to a non-significant HR of 1.19 (0.93–1.56) for disability/death and prolonged disability-free survival by 3.26 (2.33–4.18) years than those with unfavourable profile. Conclusions: Healthy lifestyle and/or moderate-to-rich social network attenuates the risk of diabetes on disability/death and prolongs disability-free survival in people with diabetes by 3 years.

IMPLEMENTATION OF A SHARED DECISION-MAKING TOOL FOR OSTEOARTHRITIS TREATMENT TO REDUCE DECISIONAL CONFLICT

Yashika Watkins,[1] Rose Gonzalez,[2] Charla Johnson,[3] and Ravneet Kaur,[4] *1. Chicago State University, Cliffside Park, New Jersey, United States, 2. Movement is Life, Lake Ridge, Virginia, United States, 3. Franciscan Missionaries of Our Lady Health System, Baton Rouge, Louisiana, United States, 4. University of Illinois at Chicago, Crown Point, Indiana, United States*

Shared decision making is a key component of patient centered care where clinical evidence and the patient's preference and values are considered. Physical activity and weight loss are often recommendations in the treatment plan, especially in mild to moderate stage of osteoarthritis (OA). Movement is Life (MIL) created an innovative SDM tool to provide a framework for patient-centered discussions. The tool leverages an underlying Markov Model and represents the likely pain, activity levels, and lost productivity at three future time points. By comparing the patient's likely progression depending on treatment choices compared to doing nothing, the patient has an illustration of future state. A pilot of N=108 women, ages 45-64, with chronic knee pain for at least three months and at least one co-morbidity (obesity, hypertension, diabetes) were randomized to a control (n=54) or intervention (n=54) arm of the study at eight centers across the United States. Results showed the demographic profiles were similar between the groups. At one-month, n=47 control and n=50