Worldwide trends in health risks, lifestyle behaviors, health perceptions, and health-seeking patterns suggest alarming disparities among individuals from low- and middle-income countries; particularly for older individuals (≥ 60 years). This study aims to compare health risks, perceptions, lifestyle behaviors, and health-seeking patterns between younger (< 60 years) and older (≥ 60 years) Filipinos from rural communities in the Philippines; and assess relationships between demographic, health risks and perceptions, and lifestyle behaviors to bolster health promotion efforts. A comparative cross-sectional study was employed with 863 younger and 427 older Filipinos. Results show that older participants were more likely to be single/widowed and had ≤ high school education. Older participants had higher rates of hypertension, dyslipidemia, diabetes, and depression but were more likely to report higher quality of life, ≥ 150 minutes of physical activity per week, ≥ 5 servings of fruits and vegetable per day, more difficulty falling asleep, report seeing a physician regularly, going to the community health center when sick, and attend stress management classes compared to their younger counterparts (all p's < .001). There were no differences in rates of obesity, self-medication, and use of integrative health. Older age was associated with higher risks, improved health perceptions, healthier lifestyle behaviors, and better health-seeking patterns. Our data suggest that health risks are higher in older individuals but risky lifestyle behaviors were higher in younger individuals and suggest the need to design separate health promotion interventions that target the unique needs of older and younger Filipinos from rural communities.

IMMIGRATION-RELATED FACTORS AND DEPRESSION HELP-SEEKING AMONG OLDER CHINESE AMERICANS

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Asian Americans have the lowest mental health service utilization rate among all racial/ethnic groups. One important yet understudied aspect of this group’s mental health service use is its potential associations with immigration-related factors such as migration reasons, years in U.S., acculturation, and ethnic enclave residence. Using data from the Population-based Study of Chinese Elderly in Chicago (collected 2013-2015, N=3,123), this study investigates whether and how immigration-related factors shape mental health service utilization. Four categories of help-seeking behaviors for depressive symptoms were examined, including not seeking help (23.5%), seeking help from informal source(s) only (40%), seeking help from both informal and formal sources (28.7%), and seeking help from formal source(s) only (8.8%). Results of logistic regressions showed that U.S. Chinese older adults who migrated for family reasons were less likely to seek help from informal sources only than those who migrated for other reasons (Odds Ratio (OR) = 0.64, 95% Confidence Interval (CI) = 0.42-0.99). Less acculturated older immigrants (OR = 0.88, 95% CI = 0.79-0.97) and those who lived in Chinatown (OR = 2.34, 95% CI = 1.21-4.52) were more likely to seek help from formal sources only (relative to not seeking any help). Our findings showed that majority of the older Chinese Americans with depressive symptoms either did not seek help or sought help from informal sources only. Their help-seeking behaviors were shaped by their migration and acculturation experiences. Leveraging informal support networks and ethnicity-specific resources in Chinatown represent a culturally appropriate approach to facilitate mental health help-seeking among U.S. Chinese older adults.

ROLE OF DISEASE-SPECIFIC INCIDENCE AND SURVIVAL IN DISPARITIES IN LIFE EXPECTANCY IN THE UNITED STATES

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There are persisting geographic and racial disparities in life expectancy (LE) across the United States (US). We used 5% Medicare Claims data (2000-2017) to investigate how disease incidence and survival contribute to such disparities. Disease-specific hazard ratios (HRs) were calculated for Medicare beneficiaries living in the US states with the lowest LE (the states with the highest LE were used as a reference group), in gender- and race-ethnicity-specific populations. Analysis of incidence showed that the greatest contribution to between-the-state disparities in LE was due to higher incidence (HRs ≥ 1.30) of atherosclerosis, heart failure, influenza/pneumonia, Alzheimer’s disease, and lung cancer among older adults living in the states with the lowest LE. The list of diseases that contributed most to LE through the differences in their survival substantially differed from the above listed diseases: namely, diabetes, chronic ischemic heart disease, and cerebrovascular disease had HRs ≥ 1.28 for their respective survival rates, with the highest HRs for lung cancer (HR = 1.37, in females) and prostate cancer (HR = 1.30). Respective race-ethnicity-specific patterns of incidence and survival HRs were investigated and diseases contributed most to racial disparities in LE were identified. Study showed that when planning the strategies targeting between-the-state differences in LE in the US, it is important to address both 1) primary and secondary prevention for diseases demonstrating substantial differences in contributions of incidence, and 2) treatment choice, adherence to treatment, and comorbidities for diseases contributing to LE disparities predominantly through the differences in survival. Such strategies can be disease-, race-ethnicity-, and geographic area-specific.

SLOWDOWN IN LIFE EXPECTANCY IMPROVEMENTS FOR EUROPEAN COUNTRIES FROM 2000 TO 2019

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Life expectancy improvements have slowed across Europe since around 2010 for unknown reasons. We aimed to assess
the contribution of specific conditions and risk factors to changes in life expectancy. We compared Global Burden of Disease (GBD) 2019 estimates for life expectancy at birth, years of life lost to premature mortality (YLLs) and population attributable fractions (PAFs) for risk factors, for 17 European Economic Area (EEA) countries from 2000 to 2010 and from 2010 to 2019. All 17 countries experienced a slowdown in life expectancy improvements after 2010, after decades of improvement. Denmark experienced the smallest drop in improvement from 2000 to 2010 compared to 2010 to 2019 (0.75 years drop), followed by Norway (0.79), Iceland (0.86), Finland and Sweden (both 0.89). The 5 countries with the largest drop in improvement were Spain (1.6 years drop), the Netherlands (1.88), Portugal (1.92), the United Kingdom (UK) (2.13), and Ireland (2.77). Ischaemic heart disease and stroke made the biggest contribution to the slowdown in life expectancy. Important risk factors for mortality varied by country and included tobacco, drug and alcohol use, and high fasting plasma glucose. The Nordic countries have maintained improvements in life expectancy substantially better than other European countries. The different patterns in different countries suggest multiple factors are contributing to the changes, including specific conditions, risks and behaviours, and broader societal determinants of health. Large scale, international, co-ordinated research is needed to better understand these changes and inform policy actions, particularly as the COVID-19 pandemic will increase international differences.

Session 2065 (Symposium)

DISRUPTION TO TRANSFORMATION: ENGAGED RESEARCH
Chair: Carol Geary Co-Chair: Katherine Abbott Discussant: Erin McGaffigan

With changes in funders’ requirements, engagement of persons with “lived experience” in the planning, conduct, and dissemination of research is increasingly common. Although patient and stakeholder engagement is expected, the body of literature describing necessary structures and processes is severely limited. Therefore, the purpose of this symposium is to aid in the movement of engaged research from disruption to translation. To do so, we will describe gaps in researcher knowledge and skills associated with patient and stakeholder engagement; structures and processes in current use with older adults, and outcomes associated with engagement. We will begin by sharing findings within advisory board models of engagement. Dr. Lessem will describe the Sage Resource Project researcher needs assessment. Researchers (N=103) shared both their engagement interests and their perceived knowledge and capability gaps. Dr. Berman will describe training developed within the same project to overcome researchers’ perceived gaps. Then, Dr. Roes will describe a qualitative evaluation of persons with dementia perspectives on rewards and benefits of advisory board involvement. Our final two presenters will describe engagement using a variety of engagement approaches. Dr. Douglas will share experiences with adapting Montessori philosophies and processes to engage CNAs in development of innovative programming for dementia care within a long term care environment. Finally, Dr. Geary will share her team’s findings from interviews completed using appreciative inquiry with sites with over five-years’ experience engaging patients in research. Each site has developed unique infrastructures and processes to most effectively achieve desired outcomes.

STRUCTURE, PROCESS AND OUTCOMES IN PATIENT ENGAGEMENT
June Eilers, Cheryl Jernigan, Kim Kimminau, and Carol Geary

Although patient engagement in research is gaining acceptance by researchers and funding bodies, descriptions of implementation options and associated outcomes are limited. In this appreciative inquiry of the 12 institutions involved in the Great Plains Collaborative of the Patient-Centered Outcomes Research Network (PCORnet), we interviewed patient engagement officers and patient partners to enhance understanding of approaches to organizational structure, research engagement processes, and associated outcomes of the engaged research. Multiple structures have been identified including operational affiliations in both hospital and multiple university departments. Professional affiliations of patient engagement officers vary widely, including nurses, social workers, and public health professionals, among others. Patient engagement processes also vary, but with the majority using forms of advisory boards. All sites reported outcomes of their work including completed and/or ongoing research and co-authored publications.

THE SAGE RESOURCE PROJECT: READYING RESEARCHERS TO TRANSFORM RESEARCH THROUGH ENGAGEMENT
Rebecca Berman, Jesse Bella, Margaret Danilovich, and Rachel Lessem

The Sage Model enables engagement of older adults receiving Long Term Services and Supports (LTSS), a group typically excluded in research. This presentation focuses on lessons learned from The Sage Resource Project, a Patient Centered Outcomes Research Institute funded project. We collaborated with RCMAR and Royal centers to encourage NIH-affiliated researchers to embrace stakeholder engagement through promotion of the Sage Model. Few studies include an assessment of researcher needs when it comes to stakeholder engagement. We conducted a needs assessment (n=103) finding <50% of researchers presented work to older adults and only 41% interacted with older adults receiving LTSS. However, >90% were likely to attend webinars to learn more. Additionally, 70% of respondents were interested in setting up their own Sage Model research advisory boards. We identify opportunities for transforming LTSS research by including older adults as well as directions for future research on engagement, based on researchers’ identified needs.