in Massachusetts with implications for program monitoring and process evaluation. Second, Epps & colleagues will discuss the process of developing a person-centered tool to evaluate the impact of dementia-friendly programs in faith-based communities. Third, Somerville & colleagues will present findings from a study of community and organizational factors related to dementia-friendly readiness in community-based senior centers. Finally, Sun & colleagues will discuss the barriers and facilitators to implementation of DFCs in the USA during the COVID-19 pandemic. Taken together, these studies demonstrate the utility of quantitative and qualitative research methodologies to elucidate how and to what extent DFCs are implemented. Findings have implications for examining the population health impact of DFC efforts, as well as for attending to issues of health disparities and aging equity in the uptake, implementation, and sustainability of DFC initiatives.

DIMENSIONS OF IMPLEMENTATION FOR DEMENTIA-FRIENDLY COMMUNITY INITIATIVES

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Dementia-friendly community (DFC) initiatives are a community-level approach to support individuals living with dementia and their care partners. DFC initiatives engage in a range of activities including raising awareness about dementia, enhancing local services, and advocating for inclusive public facilities and spaces. There is significant variation in the implementation of DFC initiatives worldwide which creates challenges for both process and outcomes evaluation. We used data from qualitative interviews with DFC leaders in Massachusetts to develop a framework to assess the implementation of DFC initiatives. Qualitative descriptive analysis yielded distinct dimensions such as robustness of multisectoral action teams, diversity of strategies for outreach to older adults, and degree of focus on coordinating care. Building on the tradition of using radar charts to evaluate DFC initiatives, we visualized the shape of implementation across the various dimensions. This framework can help to advance research, practice, and policy as part of the DFC movement.

DEVELOPING A MEASURE OF COMMUNITY-LEVEL DEMENTIA FRIENDLINESS IN FAITH COMMUNITIES

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As the prevalence of dementia rises, modifying built and social environments of persons living with dementia (PLWD) becomes increasingly essential. Although there is a call to rigorously evaluate dementia-friendly community initiatives, no known comprehensive evaluation tools exist to assess small communities (churches and community centers). Therefore, we are developing a person-centered Dementia-Friendly Community Assessment tool. This tool will consist of new and validated scales to assess the level of dementia-friendliness among churches enrolled in a dementia-friendly congregation program based in African American communities. A draft of a theory-informed survey instrument is being shared with stakeholders (church leaders, caregivers, and PLWD) during focus groups who will provide feedback on their understanding and relevance of questions on the instrument. The tool will then be modified based on feedback and the final instrument will be piloted with broad church membership. Our aim is to enable programs to quantify their dementia-friendly community initiative’s impact.

PERCEPTIONS OF DEMENTIA FRIENDLY COMMUNITY STAKEHOLDERS IN THE US: CHALLENGES AND STRATEGIES DURING COVID-19

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This study examines the challenges faced by Dementia Friendly Communities (DFC) during COVID-19 pandemic and the strategies used to address these challenges from the perspectives of DFC stakeholders in the U.S. Data were collected in 2020 through an online survey of 183 stakeholders (Mage =35.3, SD=8.8, 43.6% being female) involved who were in DFC design, implementation, or evaluation. Three challenges rated most critical by participants included limited funding (40.4%), difficulties to provide services due to policies to contain COVID-19 (35.7%), and lack of staffing (29.3%). Three rated most important strategies included seeking funding and government support (31.1%), developing partnerships and relationships with multiple sectors (29.1%), and recruiting persons with dementia and family caregivers as advocates (27.5%). Communities demonstrated resilience during the COVID-19 pandemic to implement DFC-related activities. To sustain DFC, enhancing national awareness, acquiring additional funding, and firm cogency from staff members, local/state government, and local communities are needed.

SENIOR CENTER INVOLVEMENT WITH DEMENTIA-FRIENDLY COMMUNITIES: COMMUNITY AND ORGANIZATIONAL FACTORS

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As local hubs for aging services, senior centers are well-positioned to engage in dementia-friendly community (DFC) work. Yet centers vary in their engagement, especially as the DFC concept has been introduced only recently in the US. Using a mixed-methods approach, we drew on data from a survey of senior centers in Massachusetts, the US Census, and qualitative interviews with senior center staff to examine factors associated with DFC engagement. Centers that reported greater engagement were in municipalities with higher proportions of older residents from vulnerable groups (e.g., adults ages 80+, limited English proficiency, with a disability, living alone). They also reported greater programmatic, social service, funding, and staff capacity. Qualitative findings elucidated how senior center leaders drew on interpersonal, interpersonal, organizational, and community assets to support local DFC efforts. We discuss implications for policies and practices to cultivate senior centers and other
community-based organizations as leaders and partners toward DFCs.

**SESSION 1180 (PAPER)**

**AGING IN PLACE AND COMMUNITIES**

A QUALITATIVE STUDY EXPLORING OLDER ADULTS’ PERCEPTIONS, FACILITATORS, AND BARRIERS IN PLANNING FOR AGING AND FRAILITY

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Aging in place is often a desired aspect of the aging trajectory but too often older adults and society in general do not consider the factors involved in planning to make this a reality. Planning for aging and frailty entails a comprehensive life course approach to planning for one’s aging process in five unique domains: communication/socialization, environmental, financial, physical care, and cognitive status. In order to promote upstream planning, there is a need to explore the lived experiences of older adults through understanding their viewpoints on planning, and what may promote or hinder this process. The purpose of this study was to explore how people perceive the concept of planning for aging and frailty and to identify facilitators and barriers involved in planning efforts. Using semi-structured questions, 20 community-dwelling older adults (aged 50-80) were interviewed. In-vivo coding and descriptive content analysis was utilized and revealed 17 codes within categories, including six codes and three categories in the perception domain (internal, external, future-oriented), seven codes and three categories in the facilitators domain (internal, external, systems), and four codes and two categories in the barriers domain (internal, systems). The depth of older adults’ personal identities, life experiences, and the impact of societal influences emerged within the categories. Planning for aging and frailty is an unique concept that promotes planning through awareness and acceptance of the normal aging process. Future research through intervention development is needed to educate and empower older adults, optimize planning, and navigate barriers to planning.

COMMUNITY CONTEXT OF OLDER ADULT CARE: A CASE STUDY DURING THE COVID-19 PANDEMIC

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Introduction: Expectations for older adults (OA) to live in the community and prevent costly long-term care assume OAs’ informal network members are available, able, and willing to fill this need. Yet, little is known about the processes whereby OAs construct care networks, especially during COVID-19.

Methods: A longitudinal case study of one OA male who participated in the ethnographic community Older Adult Care study in one urban Chicago neighborhood is described. The OA male described his network on three occasions: 2/2018, 1/2021 and 9/2021. The care networks were described by size, density, and transitivity. Data analysis was performed using the R programming language. Adjacency networks were constructed using the network package, then visualized using the ninja package.

Results: The OAs network went from 23 members pre-pandemic in time one to 13 in time two and 8 members in time three. As network size contracted, the network density increased from 25% in time two to 46% at time three, indicating a more interconnected network. Clustering varied over time and was at its lowest in time 2 (27%) and increased by time 3 (67%). Friends and church connections were 72% of his network in time one, whereas 71% of his network were family and neighbors in time three.

Conclusions: Our OAs large, relatively disconnected social network tightened to fewer, more closely connected members during COVID-19 months. Contextual variables (environment, health guidelines, fear, pets) influenced the networks. It is essential to understand OA care networks to promote healthy aging in community.

**EARLY DETECTION AND MANAGEMENT OF FRAILTY IN PRIMARY CARE: VALIDATION OF THE EFI-CGA WITH ELECTRONIC HEALTH RECORDS**

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Background: Frailty is common in older adults and associated with many adverse outcomes. To promote early detection and management of frailty outside specialized geriatric services, we developed an electronic Frailty Index based on a Comprehensive Geriatric Assessment (eFI-CGA) in electronic health records. Here, we compare the eFI-CGA assessments between family physicians (FP) and geriatricians (GM).

Methods: Data from community-dwelling older adults were collected as part of the collaborative effort between Fraser Health and Nova Scotia Health to validate the eFI-CGA. The eFI-CGA was created following a standard procedure based on understanding deficit accumulation. A FP and a GM assessed each patient independently. Characteristics of the eFI-CGA were examined for each physician group using descriptive statistics and correlation analysis. FP-GM inter-rater reliability was tested using Cohen’s Kappa.

Results: The first 30 cases were aged 80.8±5.2 years; 7% were women; with 12.9±2.8 years of education; 17% lived alone. Mild cognitive impairment or dementia was present in 20% participants. The mean clinical frailty scale (CFS) was 3 and the mean eFI-CGA was 0.20 by both FP and GM ratings. The CFS and eFI-CGA were closely correlated (r=0.76 for FP and r=0.71 for GM, p<.001). The eFI-CGA also showed an age correlation (r values =0.37, p values ≤.050). The average intraclass correlation coefficient was 0.79 for CFS and 0.90 for eFI-CGA (each p<.001).

Conclusion: Frailty data collected in primary care are highly comparable with geriatrician assessments. Ongoing