to the community health educator and to physical and occupational therapy.

NURSE PRACTITIONER’S ROLE AS 3D TEAM LEADER
Kathleen Obuchon, UConn Health, Farmington, Connecticut, United States

The nurse practitioner’s (NP) clinical activities during the 12-month intervention period include 4 monthly in-home visits and 8 monthly telephone contacts. This presentation will detail the clinical assessments and activities conducted during the initial home visit, and how subsequent home visit activities and interventions are structured for older adults and their informal caregivers depending on whether older adults have dementia, depression, and/or recent delirium. Because the potential for medication-related problems is a critical concern for older adults with cognitive vulnerability, this presentation also will detail how the NP works with the 3D Team pharmacist to determine potential inappropriate medications through a review and reconciliation process, and how the NP and pharmacist summarize these results and correspond accordingly with the older adult’s primary care physician. Finally, this presentation will explain how the NP manages communication among members of the 3D Team who provide interventions to the same older adult and caregiver.

NURSE PRACTITIONER’S CLINICAL TRIGGERS FOR REFERRAL TO OTHER 3D TEAM MEMBERS
Shawn Ladda, UConn Health, Farmington, Connecticut, United States

This presentation features how 3D Team nurse practitioners (NP) use results of clinical assessments to determine whether older adults and caregivers enrolled in the study are referred to other Team members; these assessment results are called “clinical triggers”. Other team members who receive referrals based on NP-generated clinical triggers include: Licensed Clinical Social Workers, who deliver Problem Solving Therapy to older adults with significant depressive symptoms; Occupational Therapists, who deliver an evidence-based dementia care intervention; Physical Therapists, who deliver an adapted Otago exercise program; Registered Dietician, who provides nutrition and dietary instruction; and Community Health Educator, who provides community resource information to address social determinants of health. All clinical triggers will be detailed in this presentation, along with a description of each intervention delivered by other team members except the Community Health Educator. Case studies will be presented to illustrate how study participants receive multiple interventions from the 3D Team.

COMMUNITY HEALTH EDUCATOR’S ROLE ON THE 3D TEAM
Alba Santiago, UConn Health, Farmington, Connecticut, United States

As a member of the 3D Team, the bilingual, bicultural Community Health Educator (CHE) addresses needs expressed by study participants related to social determinants of health. Clinical triggers generated by nurse practitioners (NPs) that lead to CHE referral include: social isolation and loneliness; lack of transportation access; lack of resources to sustain nutritional adequacy, purchase medications, and purchase assistive devices; and cultural and linguistic barriers that lead to lack of knowledge about community resources. To date, 50% of study participants randomized to receive 3D Team care have triggered referral to the CHE. In this presentation, the team CHE will provide details on the frequency of different needs expressed by study participants, how she utilizes an ever-growing community resource directory, and specific types of information and guidance she provides to address their expressed needs. Case studies will help illustrate ways in which CHE services have successfully provided assistance to study participants.

SESSION 7005 (SYMPOSIUM)
ADVANCING ALZHEIMER’S DISEASE CARE AND SERVICES AMONG RACIAL AND ETHNIC MINORITIES
Chair: Lenora Smith
Discussant: Roland Thorpe, Jr.

Research shows consistent and adverse disparities among racial and ethnic minorities compared to non-Hispanic Whites in the prevalence and incidence of Alzheimer’s disease, mortality, participation in clinical trials, use of medications and other interventions, health care expenditures, and quality-of-life outcomes. The literature suggests numerous underlying causes, including factors related to measurement of the disease, genetics, socioeconomic factors, cultural differences, lack of culturally competent interventions, and discrimination in services and care. Although these disparities are well known, little is known about the effectiveness of various strategies to address these differences within the context of Alzheimer’s disease services and care. This symposium aims to contribute to this knowledge. The first presentation examines the role of race with marital status and risk for dementia using data from the Health and Retirement Study. Results suggest differences for unmarried White and unmarried older adults of color, which can inform dementia care services. The second presentation highlights the opportunities and challenges of facilitating cognitive impairment screenings among African American congregations. The third presentation introduces strategies to address these differences within the context of Alzheimer’s disease services and care. The second presentation details how the NP works with the 3D Team pharmacist to determine potential inappropriate medications through a review and reconciliation process, and how the NP and pharmacist summarize these results and correspond accordingly with the older adult’s primary care physician. Finally, this presentation will explain how the NP manages communication among members of the 3D Team who provide interventions to the same older adult and caregiver.

MINORITIES AND SERVICES AMONG RACIAL AND ETHNIC MINORITIES
Discussant: Roland Thorpe, Jr.

Previous research has shown that unmarried individuals (i.e., divorced, widowed, and never married) had a higher risk of dementia than their married counterparts. However, few studies examined whether the link between marital...
status and dementia varies by race. To fill the gap, we used data from the Health and Retirement Longitudinal Study (2000-2014) and analyzed 15,379 respondents (13,278 non-Hispanic whites and 2,101 non-Hispanic blacks) ages 50 and older in 2000 who had no dementia. Discrete-time event history models were estimated. Our preliminary analysis showed that marital status was significantly associated with the odds of dementia for both whites and blacks. Furthermore, the associations between unmarried status (i.e., cohabiting, widowed, and never married) and dementia were stronger among blacks than whites. The effect of divorce on odds of dementia did not differ by race. The results were robust after controlling for socioeconomic status, health and lifestyle factors, and social engagements. Part of a symposium sponsored by the Alzheimer’s Disease Research Interest Group.

SCREENING FOR COGNITIVE IMPAIRMENT IN AFRICAN AMERICAN CONGREGATIONS

Fayron Epps, Emory University, Atlanta, Georgia, United States

Having access to memory screenings is pivotal to early detection in the African American (AA) community. The purpose of this report is to describe the willingness and perceived barriers of AA congregants to participate in memory screenings. Out of 283 attendees to dementia-related church forums, 26% (n = 73) of the attendees participated in private memory screenings. The majority of the participants were female (88%), n = 64). Under half of the participants (37%, n = 27) scored below normal with 81% (n = 22) being female. Several attendees declined the opportunity to have their memory screened for various reasons. These results support how women are disproportionately affected by cognitive impairment. Another alarming point was the low participation in memory screenings of event attendees. This report is important because it raises awareness of the need within the AA community, who are at a higher risk for memory loss, to receive screening. Part of a symposium sponsored by the Alzheimer’s Disease Research Interest Group.

ATTITUDES ABOUT BRAIN DONATION AMONG AFRICAN AMERICAN RESEARCH PARTICIPANTS

Deborah Dyslin,1 Sara Dunlop,1 Brenda Aldridge,2 Robin Tillotson,3 and Darby Morhardt,1 1. Northwestern University, Chicago, Illinois, United States, 2. SouthEast (Atlas) Regional Senior Center, Chicago, Illinois, United States, 3. Chicago Department of Family & Support Services, Chicago, Illinois, United States

Alzheimer’s and related dementias (ADRD) disproportionately affect the African American community. Brain donation, a crucial part of translational research, is less common among African American research participants compared to White research participants at Alzheimer’s Disease Research Centers (ADRCs) across the US. Existing literature suggests three categories of contributory factors for African Americans: concerns and misconceptions about brain research and brain donation; religious beliefs; and the role of the family. Existing knowledge of community interventions is limited. We conducted seven focus groups, stratified by brain donation intent and cognitive status, to capture the perspectives of African American research participants. Qualitative content analysis reveal the following contributory themes: personal connection to memory loss or dementia; altruism; spirituality/religion; historical and current racism in health care and research; trauma and objectification; trust; representation; understanding the purpose and process of brain donation; and fluidity in decision-making. Future research will explore trauma-informed and culturally responsive interventions. Part of a symposium sponsored by the Alzheimer’s Disease Research Interest Group.

HEARING CARE DISPARITIES IN DEMENTIA: ACCESS AND USABILITY IN THE COMING ERA OF OTC HEARING AIDS

Carrie Nieman,1 Jennifer Deal,2 Sara Czaja,3 and Esther Oh,1 1. Johns Hopkins University School of Medicine, Baltimore, Maryland, United States, 2. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States, 3. Weill Cornell Medicine, New York, New York, United States

Age-related hearing loss is highly prevalent among persons with dementia (PwDs) and is associated with an increased risk of neuropsychiatric symptoms. However, few use hearing aids and disparities exist. PwDs and, in particular, minority older adults, have some of the lowest rates of hearing aid use. Recent federal legislation created the designation of over-the-counter hearing aids, which will debut by 2020-2021, and represents an opportunity to advance accessibility. This presentation will share estimates of hearing aid use among community-dwelling PwDs from two cohorts, where hearing aid use ranges from 7-11% among African Americans versus 33-45% among whites. To explore this gap, the presentation will share findings from semi-structured interviews with care partners of PwDs and hearing loss around barriers and facilitators of hearing care, including device usability. With growing understanding of sensory health, a changing hearing care landscape represents a critical opening to increase access to hearing care for PwDs. Part of a symposium sponsored by the Alzheimer’s Disease Research Interest Group.

SESSION 7010 (SYMPOSIUM)

ADVERSE OUTCOMES, POLYSUBSTANCE USE, AND POLYPHARMACY IN OLDER VETERANS

Chair: Amy Byers

This session will provide information about adverse health outcomes, including suicide, suicide attempts and unintended death, that may be related to polysubstance use and polypharmacy in older adults, particularly older veterans. It will further provide information that will help support late-life suicide prevention and intervention efforts. Older veterans (age 50 and older) have the highest number of lives lost to suicide, make up majority of the veteran population, and are highly likely to experience conditions (e.g., chronic pain, sleep disorders, musculoskeletal) associated with commonly prescribed medications that are potential markers for suicide risk (hereafter referred to as “high-risk” drug categories), including benzodiazepines, sedative-hypnotics, opioids, anti-depressants, antipsychotics, and antiepileptics. The research presented in this session will highlight important patterns in high-risk drug prescribing and use and related outcomes in late life. The presentations will underscore various groups of