extremity muscle strength and endurance, gait speed, stride length, and activities of daily living, and compared with baseline and posttest (at 6 months) data using Repeated measures ANOVA with contrasts. During the follow-up period, 40% of the treatment group exercised 2+ times/week (Adherer, or A), and 60% did 1 time/week or less (Non-adherer or NA). Half of NA joined a community exercise group and the rest did not do exercise due to pain in various body parts. None of A fell while 26.7% of NA and 20% of C did. At follow-up, the control group (C, n=25) showed no change or significant decline from posttest for all measures. A maintained gains made in the intervention period in all measures, but NA significantly lost strength in hamstrings, hip abduction, and quadriceps and hamstring endurance. These results indicate that low-to-moderate intensity exercise and technology use for providing visual instruction, regular monitoring and evaluation, and environments to increase participants’ accountability are elements for successful home-based exercise programs.

OUTCOMES OF FIT & STRONG! PLUS: A GROUP EXERCISE AND WEIGHT LOSS PROGRAM TO TREAT OSTEOARTHRITIS

Andrew DeMott,1 and Susan Hughes1, I. University of Illinois at Chicago, Chicago, Illinois, United States

Overweight older adults with osteoarthritis (OA) face increased risk for disability; however, no evidence-based programs target weight and OA simultaneously. Fit & Strong! (F&S!) is an 8-week evidence-based exercise program for persons with OA that improves lower extremity (LE) strength and mobility out to 18 months. F&S! Plus, a weight loss version of F&S! was tested against standard F&S! in a comparative effectiveness trial. Two and six-month trial outcomes were previously presented, this session will present maintenance outcomes at 12 and 18 months. This trial randomized 413 participants, 210 to F&S! and 203 to F&S! Plus. The mean sample age was 67.9, 86% female, and 92% African American. At 12 months, significant and marginally significant between-group differences favoring F&S! Plus were seen in several outcomes, including weight (p=.049), BMI (p=.04), waist circumference (p=.004), LE physical function (p=.09), 6-minute distance walk (mobility) (p=.08), 30-second chair stands (LE strength) (p=.46), and anxiety & depression (p=.08). At 18 months, only LE strength remained significantly improved for the F&S! Plus group (p=.045), however several within-group improvements remained statistically significant for both groups out to 18 months, including weight, BMI, waist circumference, LE pain & physical function, 30-second chair stands (LE strength), anxiety & depression, and self-efficacy for weight-management. F&S! Plus showed significant improvements over standard F&S! for several outcomes at the conclusion of the intervention (2 months) and many were maintained out to 12 months, with LE strength continuing to 18 months. Both groups showed significant within-group improvements out to 18 months.

RELATIONSHIP OF CARDIOPULMONARY EXERCISE TESTING AND FIELD WALKING TESTS IN MILD-MODERATE ALZHEIMER’S DEMENTIA

Derek L. Salisbury,1 and Fang Yu1, I. University of Minnesota School of Nursing, Minneapolis, Minnesota, United States

The purpose of this study was to investigate relationships among peak exercise parameters on 6-minute walk (6MWT) and shuttle walk tests (SWT), and laboratory-based cardiopulmonary exercise testing (CPET). These relationships have been established in cardiopulmonary patient populations, but not in community-dwelling older adults with mild-moderate Alzheimer’s dementia (AD). This study is a cross-sectional analysis of the baseline data of 6MWT, SWT, and CPET from the FIT-AD Trial (n=88: 49 males [76.6 [7.0] years and MMSE 21.5 [3.5]] and 39 females [77.3 [6.5] years and MMSE 22.1 [3.4]]. Peak values for each test included heart rate (HR), systolic blood pressure (SBP), and rating of perceived exertion (RPE). Peak oxygen consumption (VO2) was measured in the CPET. Peak walking distance (PWD) was measured for the 6MWT and SWT. CPET produced significantly higher peak HR (118.7 [17.5] vs. 106 [22.8] vs. 106 [18.8] bpm), RPE (16 [2.1] vs. 12 [2.3] vs. 11 [2.1]) and SBP (182 [23.7] vs. 156 [18.9] vs. 150 [16.9] mmHg) compared to the SWT and 6MWT respectively. PWD on SWT (240.4 [128.1] m) and 6MWT (364.3 [108.5] m) significantly correlated with peak VO2 (17.0 [4.3]ml/kg/min) on CPET (r=.44 and r=.43 respectively. Correlations of peak VO2 and PWD on SWT in persons with AD are considerably lower than what is seen for persons with cardiopulmonary diseases. This lower correlation seen in our sample may be due to shorter PWD on walking tests. Future research should focus how mobility affects correlation of peak values on these tests.

RESPONDERS TO A PHYSICAL ACTIVITY COACHING PROGRAM IN COPD

Huong Q. Nguyen,1 Amy Liu,1 Janet Lee,1 and Anny Xiang1, I. Kaiser Permanente Southern California, Pasadena, California, United States

Rationale: Physical inactivity is associated with worse outcomes in COPD. There remains a critical gap regarding the real-world effectiveness of improving physical activity (PA) in large representative samples of older adults with COPD and its impact on hospitalizations. Methods: A pragmatic randomized trial was conducted to determine the effectiveness of a 12-month home-based physical activity coaching intervention (Walk On!, WO) compared to standard care (SC) in 2,707 patients at high risk for COPD exacerbations. The WO intervention included collaborative monitoring of steps, semi-automated step goal recommendations, individualized reinforcement, and peer/family support. This is a subgroup analysis of 321 patients who were randomized to WO and participated in the program, matched to SC patients based on their propensity scores (PS). Multivariate cox proportional hazards models were used to determine differences in all-cause hospitalizations in the 12-months following randomization. Results: WO patients with low PS (n=160) were matched to 888 low PS SC patients and 161 WO patients with high PS (n=161) were matched to 405 high PS SC patients. Characteristics of the cohort were: age: 72±10; 54% females; 74% Caucasian; FEV1% predicted: 61±23. WO-low PS patients had lower risk of all-cause hospitalizations compared to SC-low PS patients [HR:0.69, (95%CI, 0.50, 0.96), P=.03]. WO-high PS patients did not have significantly lower hospitalization risk compared to SC-high PS patients [HR:0.87, (95%CI, 0.64, 1.20), P=.40]. Conclusions:
 Patients with COPD who had a lower propensity to participate in the physical activity coaching intervention had lower hospitalization risks compared to those with a higher participation propensity.

**SESSION 3180 (PAPER)**

**FACTORS RELATED TO FAMILY CAREGIVING**

**AN OLDER CARER, BUT STILL A CHILD: UNEXPECTED IDENTITIES OF OLDER ADULTS CARING FOR A NEAR-CENTENARIAN PARENT**

Oscar Riberio,1 Typhanie Macedo,2 and Liliana Sousa1, 1. University of Aveiro - Department of Education and Psychology | Center for Health Technology and Services Research (CINTESIS UA), Aveiro, Portugal, 2. University of Aveiro - Department of Education and Psychology, Aveiro, Portugal

According to the National Alliance for Caregiving (2015), the typical definition of an older adult caregiver points to a 79-year-old white female who cares for a close relative due to a long-term physical condition; in such cases the care-recipient is often a spouse, an adult child or a sibling, but not a parent. This cross-sectional qualitative study explores the experience of a group of fifteen children in their 70s who are main care-providers of their parents (mean age 98; range 95-105); it focuses on their overall caregiving experience with a particular emphasis on how they feel being still a child at such an advanced age. In-depth interviews were conducted and analyzed for recurrent themes using thematic analysis. Main findings revealed that although being in an overall positive experience, often socially exalted (proudness of having a parent alive/being in an unique situation), none had expected to be holding the identity of a child at their current age. These children’s views of their ageing self were strongly embedded in their caregiving role, and some reported losing awareness of their own age and a mixture of feelings of being simultaneously a child, a parent and a grandparent. Role captivity (late life prison) and disregarding self-care shaped their current situation in terms of caregiving burden and altered life plans as older adults. This study adds to the limited available knowledge on very old caregiving dyads, and raises awareness on how personal and family identity may be shaped in older age by unforeseen family dynamics.

**HEALTH CARE PROVIDER ATTITUDES ABOUT INTEGRATING FAMILY CAREGIVERS INTO CLINICAL ENCOUNTERS**

Joan M. Griffin,1 Rachel Havyer,2 Karen Schaepe,2 Catherine Riffin,3 and Lauren R. Bangerter2, 1. Mayo Clinic, Rochester, United States, 2. Mayo Clinic, Rochester, Minnesota, United States, 3. Weill Cornell Medicine, New York, New York, United States

The presence of family caregivers in clinical encounters is becoming more common with the aging of the US population and the continued shift of care responsibilities from health professionals in clinical settings to family caregivers at home. Patients accompanied to clinical encounters by caregivers are more likely to be older, sicker, and have lower health literacy.

Research shows, however, that providers often do not initiate any caregiver participation and when they do, conversations center on relaying technical medical information rather than preferences and capacity to provide caregiving assistance. Little is known about provider perceptions of engaging caregivers in clinical encounters. Using data from 20 semi-structured interviews with physicians from primary and specialty care, we identified 3 inter-related themes about engaging caregivers in clinical encounters: 1) ambivalence about caregivers’ role in clinical encounters; 2) trepidation about posing questions directly to caregivers; and, 3) beliefs that systemic barriers exist that inhibit integration of caregivers. Providers, especially in primary care encounters, chiefly view caregivers as sources of supplemental information or for absorbing or reinforcing clinical instructions for care at home. Providers also voiced concerns about the ethics of assessing caregiver capacity to provide assistance to the patient without having clinical authority to treat or adequate resources to provide to caregivers. Finally, providers identified structural barriers, including time constraints, for integrating caregivers into the clinical care team. Findings provide insight into provider attitudes on the caregivers’ role, a perspective that is essential for understanding opportunities and challenges for implementing caregiver interventions in clinical settings.

**PROVIDING AND RECEIVING FAMILY CARE ACROSS THE LIFE COURSE: INSIGHTS FROM THE OLDEST OLD**

Taylor Patskanick,1 Julie Miller,2 Chaiwoo Lee,1 and Lisa D’Ambrosio2, 1. Massachusetts Institute of Technology, Cambridge, Massachusetts, United States, 2. MIT AgeLab, Cambridge, Massachusetts, United States

Unprecedented longevity comes with an increased need for providing and receiving care. A 2015 report estimated 39.8 million adults in the United States provided unpaid care to an adult in 2014 (NAC & AARP). Previous research has focused disproportionately on experiences of providing care to older adults, but little has explored experiences of providing care and receiving care among the oldest old. Adults aged 85 and older are likely to have provided care to an adult family member at some point in their lives, but now may be receiving care themselves. The presentation will report on findings from a mixed methods study investigating the experiences of providing and receiving care across the life course among a sample of the “oldest old.” Data drawn from focus groups and a survey with the MIT AgeLab Lifestyle Leaders, a bimonthly panel study of adults ages 85 and older. Findings suggest the Lifestyle Leaders had extensive experience providing care, particularly in older age. They most often cared for family members with long-term physical or cognitive conditions. Opinions on learning new technologies to help with caregiving and robot caregivers were mixed. The majority of the Lifestyle Leaders received regular help with at least one care task regardless of household composition or living situation. Many reported help had improved their health, but they felt like a burden to their caregivers. Even in later life, the Lifestyle Leaders had few ideas about who might take care of them if they needed care in the future.