This study explored the association between perceived control and cognitive function among stroke survivors in China. We conducted a longitudinal study and assessed perceived control (by Perceived Control in Health Care Questionnaire) and cognitive function (by Montreal Cognitive Assessment, MoCA) of 231 stroke survivors at the acute stage, 3, 6 months after onset from two stroke centers in Shanghai and Linyi from June to December 2020. General linear mixed model was used for analysis. Perceived control was at a moderate level, and the average score of MoCA showed cognitive impairment at 3 waves. Both perceived control and cognitive function improved with time. Perceived control was positively associated with cognitive function ($\beta$ = 0.08, $p < 0.001$). After controlling for stroke severity, risk factors of cognitive impairment, age, gender, and education, the association was still significant ($\beta$ = 0.04, $p < 0.001$). These findings suggest that perceived control may be a potential target in cognitive interventions for stroke survivors.

**DIFFERENCES IN COMMUNITY AND PROVIDER STAKEHOLDERS’ PERCEPTIONS ON BRAIN HEALTH SERVICE GAPS AND SCREENING NEEDS**

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Introduction: Alzheimer’s Disease and Related Dementias (ADRD) management and prevention is a priority for providers and community members. Aligning perceptions regarding resources and screening supports person-centered care while addressing the increased dementia burden attributed to systemic inequity and health disparities. This project aimed to identify needs in lower-income diverse populations. Research Question: What are the differences in perceived service gaps and screening preferences for brain health and ADRD?

Methods: A convenience sample of 15 providers and 20 community stakeholders (55+) completed a 2021 survey about Richmond’s service gaps and screening needs for brain health and ADRD.

Results: 40% of providers were ADRD focused, 65% of community members reported a memory concern. Overall, providers reported fewer service gaps: Administration on Aging Service Gaps 46.7%/75%, Caregiving gaps 80%/85%, Specialty Health gaps: 53.3%/80%. Clinical ADRD gaps 73.3%/80%, Memory Case Management gaps 86.7%/90%, Memory Social Services gaps 33.3%/90%, Memory Screening gaps 53.3%/85%. Provider and Community stakeholders were more aligned regarding screenings that should be included in a brain health/ADRD management program: Advance Care Planning screening: 80%/80%, Caregiving Status screening: 93.3%/90%, Memory Loss screening: Lifestyle Risk screening: 100%/95%, Cognitive-Comorbidity Risks screening: 100%/75%, Psychosocial Risks screening:100%/100%, Depression screening 100%/100%, Clinical Health screening 73.3%/90%, Substance Use Disorder screening 86%/75%, Sleep Problem screening 93%/75%.

Conclusion: Although there were areas in which both providers and community members aligned, results show that providers underestimate brain health/ADRD service gaps experienced by the community. Both groups are amenable to comprehensive screening for services. However, providers are interested in more expansive ADRD screeners.

**CROSS-CULTURAL DIFFERENCES IN AGE ESTIMATION AND AGE BIAS**

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Our society is aging rapidly with older adults composing a continuously growing proportion of the population. This expected shift in population age is likely going to carry societal consequences, such as an increase in age discrimination. Previous research has shown that ageism (the systematic stereotyping and categorizing of people based on their age) is the most experienced kind of prejudice across Europe, with individualistic, industrialized countries like the USA and Germany showing greater levels of age bias towards the elderly. The current study aimed to investigate cross-cultural differences in age estimation and attitudes towards older adults. Pilot measures included 102 participants (65 American, 37 German) who estimated the age of 12 male celebrities representing three different age groups (young, middle, and older adult) and completed the Fraboni Scale of Ageism (FSA), a survey measurement investigating ageism. Although the Fraboni scale has been validated in other countries, it has not yet been translated to German, nor tested on a primarily German-speaking population. Preliminary analyses showed that both the original FSA scale and the German translation were reliable ($\alpha_{\text{Original}} = 0.909$, $\alpha_{\text{German}} = 0.703$), however, t-test revealed significant differences between the FSA mean scores of the original scale ($M = 1.78$, $SD = .34$) and the translated version ($M = 3.15$, $SD = .28$), $t(100) = -20.90$, $p < .001$. The researchers are currently recruiting 400 additional participants to explore the effects of culture, race, and participant age on age estimation and further validate the German translation of the scale.

**INCLUSION OF ETHNICALLY DIVERSE POPULATIONS IN CLINICAL TRIALS OF HEALTHSPAN: IMPLICATIONS FROM THE SALSA STUDY**

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Background: Geroscience-guided clinical trials focused on healthspan may seek to enroll older adults initially free of chronic diseases and disability. Here we examine healthspan in the San Antonio Longitudinal Study of Aging (SALSA), a cohort of 749 community-dwelling older (65+ years) Mexican Americans (MA) and European Americans (EA), and describe prevalence and characteristics associated with poor healthspan.

Methods: Poor healthspan was defined at the SALSA baseline exam as presence of any one of: 1) chronic disease (diabetes, myocardial infarction, congestive heart failure, stroke, chronic obstructive pulmonary disease, or cancer);