Approximately 60% of those with dementia do not carry a diagnosis, undermining patient participation in clinical trials and family access to support. Under-diagnosis is driven by lack of knowledge about dementia, stigma, clinician inexperience and therapeutic nihilism. To address clinician-based contributors to under-diagnosis, we developed and implemented “Dementia 360,” a telementoring program modeled on the ECHO (Extension for Community Health Outreach) framework. Remote participants (n=67) learned about the diagnostic process, pharmacological management, family support and dementia-related resources. The video-conference-based one-hour sessions occurred weekly over 2 months. Instruction was provided by a multi-disciplinary faculty team with extensive clinical experience. Didactic presentations were followed by case studies offered by participants. Physicians, nurses, psychologists and social workers from 40 organizations participated, of which 62% were from medically underserved rural clinics. Participants were administered pre- and post-program questionnaires about their level of confidence in assessing and treating individuals with memory loss and dementia-related behavioral symptoms. Of the 54 clinicians who completed pre-intervention confidence assessments, 30 completed post-assessment. The clinicians had significantly increased confidence in diagnosing and treating dementia and managing behavioral symptoms of dementia (p ranging from .0002 to .003). Qualitative feedback from focus groups was generally positive, for example, “Knowing the diagnosis criteria and steps to take to rule out other diagnoses will help me more accurately diagnose and rule out dementia for my patients.” Our findings suggest that delivering case-based education via ECHO has potential to increase clinician workforce confidence in diagnosing and managing dementia.

URINARY MARKERS OF OXIDATIVE STRESS CORRESPOND TO INFECTION AND AGING IN WILD CHIMPANZES
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Oxidative stress (OS) plays a central role in aging and results from a variety of stressors, making it a powerful measure of health and a way to examine phylogenetic variation in life history. However, few urinary OS markers have been examined under field conditions, particularly in primates, and their utility to non-invasively monitor acute vs. chronic conditions is poorly understood. In this study, we examined variation in 5 urinary markers of oxidative damage and protection under 5 validation paradigms in 37 wild, adult chimpanzees living in the Kibale National Park, Uganda. We used 925 urine samples to conduct both cross-sectional and within-individual analyses of responses to acute infection and variation with age. Markers of damage (8-OHdG, F-isoprostanes, MDA-TBARS, and neopterin) and total antioxidant capacity were generally positively correlated with one another. Within individuals, all markers responded to at least one if not both types of acute infection. Markers of damage also varied with age, particularly in individuals near death. Unlike in human and rodent tissues, DNA damage in urine decreased with age, both across and within individuals near death, suggesting a potential decline in DNA repair and/or metabolic rate during senescence. Our results suggest that OS can be measured using field-collected urine and may be useful for both short- and long-term indicators of health. Our results further confirm that using multiple markers and longitudinal sampling within individuals is the most productive approach for studies that seek to determine the role of OS in health and lifespan in long-lived organisms.

MOVE UP STUDY RESULTS: WEIGHT LOSS POSITIVELY AFFECTS HEALTH-RELATED QUALITY OF LIFE BUT NOT DEPRESSIVE SYMPTOMS
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Obesity is prevalent among older adults as are increases in depressive symptoms and declines in health-related quality of life (HRQOL). Healthy weight loss and mitigating mild depressive symptoms (MDS) and HRQOL could have critical public health significance. The Mobility and Vitality Lifestyle Program (MOVE UP) led by Community Health Workers delivered 32 healthy aging/weight management group sessions over 13 months. Data from 240 participants were evaluated to assess program impact on CES-D (20-item) depressive symptom and SF-36 HRQOL scores. Participants were 88% female, 28% black/other race, 42% ≥ college-educated. Mean (SD) age was 67.6 (4.1) and BMI was 34.7 (4.7). At baseline, average CES-D score was 7.9 (7.2) and 27.9 % (N = 67) had MDS, scoring 17.1 (6.2). Results show significant mean (SD) weight change of -12.7 (13.3) lb from baseline (p<0.0001). Overall, CES-D mean (SD) score change was -0.4 (6.7) (p=0.33); participants with MDS had an average CES-D decrease of -4.4 (7.8) points (p<0.0001). Further, HRQOL improved significantly in all realms, particularly the physical component score (p<0.0001). SF-36 (SD) total score improved +1.1 (7.6), mental + 2.1 (11.7), and physical + 5.0 (16.7). Regression analyses (age/sex adjusted) demonstrate that for each 5 lb of weight loss there was an average (SEM) 3.35 (1.49) point increase in SF-36 total score (p=0.03). The mitigation of depressive symptoms in the MDS subgroup was not significantly associated with weight loss but may reflect other positive effects of the intervention experience. Conversely, positive HRQOL changes appear to be driven strongly by weight loss.

POLICY MODIFICATION, CLINICIAN TRAINING, AND ENROLLMENT OF COMMUNITY-DWELLING OLDER ADULTS TO ADOPT A MODEL OF CARE
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Partnering with a Medicaid Home and Community Based waiver, we tests implementation strategies on adoption and
sustainability of a model of care to support aging-in-place, intervening on individual capabilities and the home environment. Knowledge-to-Action model underpins the 2-arm (usual care + internal facilitation versus additive external facilitation) 3-year randomized (sites) trial statewide using an implementation strategy bundle (relationship/coalition/team building; education; interdisciplinary care/coordination; facilitation; and audit/feedback). Consolidated Framework for Implementation Research guides examining characteristics (site/RN-OT-SW/beneficiary), clinician attitude/self-efficacy, leadership/readiness to implement, and policy on adoption and sustainability; and intervention impact on beneficiary outcomes. Linear models will be used to analyze fidelity, Poison and bootstrapping gage adoption, sustainability, fidelity, and level of facilitation. Champions (internal facilitators/supervisors; N=57) were engaged and 33.3% (n=19) completed online training (1.5 hours; 7.0 [SD 2.3] understood role; 6.8 [SD 1.8] would use training: 1-10 [lo-hi]); 100% (N=19) attended monthly coalition-building meetings. RN-OT-SWs were recruited (mail); 608 of 685 (88.8%) consented and completed online education (5.5 hours; Certified). Policymakers included quality incentives in contracts (10/1/2019) with sites for >95% certified RN-OT-SWs. Beneficiaries (N=12,000) were recruited (mail); 5% (n=608) did not participate (16.1% [n=98] poor cognition; 11.5% [n=70] nursing home/assisted living; 7.1% [n=43] no needs; 5.9% [n=36] too sick; 5.2% [n=32] many caregivers; 5.1% [n=31] inability to improve; no English/hospitalized/other). Stages of Implementation Completion and fidelity data (September/October) will be reported. Adoption of models of care to support aging-in-place in Medicaid settings are a challenge, and this research harnesses a network (university/policymaker/supervisors/waiver sites-clinicians/beneficiaries) to improve care for vulnerable older adults.

THE RELATIONSHIP BETWEEN SUBJECTIVE AGE, CHRONOLOGICAL AGE, AND COGNITIVE FUNCTIONING IN OLDER ADULTS. Emily P. Morris,1 and Laura B. Zahodne1, 1. University of Michigan, Ann Arbor, Michigan, United States

Prior longitudinal research suggests that younger subjective age (i.e., feeling younger than your chronological age) predicts better subsequent cognitive functioning and lower dementia incidence independent of chronological age. However, no research has investigated interactions between subjective age and chronological age. This study examined whether older adults with more youthful subjective age performed better on cognitive evaluations than those with older subjective age and whether associations differed as a function of chronological age. Data from 1,047 older adults aged 65 and older from the Health and Retirement Study’s 2016 Harmonized Cognitive Aging Project were analyzed. Separate linear regressions estimated associations between subjective age and factor scores corresponding to five cognitive domains: executive function, episodic memory, language, visuospatial functioning, and processing speed. Covariates included sociodemographic characteristics and chronic disease burden. Interaction terms tested whether chronological age modified associations between subjective age and cognition. In the whole sample, younger subjective age was associated with better language. Significant interactions for all five domains revealed that associations were stronger and statistically significant for participants at the oldest chronological ages. The predictive value of subjective age may be highest among the oldest adults. These cross-sectional findings suggest that the oldest adults are most vulnerable to the detrimental effects of feeling older than one’s chronological age, cognitive difficulties are more relevant for subjective age perceptions for the oldest adults, and/or subjective age better reflects consequential physiological deterioration in that group. Future longitudinal research is needed to elucidate these possibilities.

FACTORS RELATED TO QUALITY OF LIFE OF OLDER PEOPLE IN TEHRAN IN 2019

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Aging is accompanied by a variety of challenges and tensions that have consequences for quality of life in older people. Optimizing quality of life is a key goal for active aging. This study was conducted to describe factors and quality of life of older people in the city of Tehran. This descriptive, correlational study was conducted on a sample of 290 older people above age 60 recruited in 10 public parks in five regions of Tehran in 2019. A socio-demographic questionnaire and instrument on Quality Of Life of Older People (QOL-OP) were used for data collection. Content validity and Cronbach's alpha were used for evaluation of the validity and reliability of questionnaires. Data were analyzed with SPSS software. Fifty-one percent of older people were male and 49% male with a mean age of 69.52(± 7.11) years. The mean scores for quality of life domains ranged from 57.61(±7.11) for family integrity, to 64.73(±7.50) for spiritual well-being on a 100-point scale. The scores on health-related quality of life domains were influenced significantly by characteristics of age, gender, marital status, housing status, income source, treatment insurance, supplementary treatment insurance, education level, living persons, number of offspring, and annual physician referral rates. The findings of this study showed that quality of life of older people was lower than expected and related to a number of factors. Monitoring modifiable factors such as treatment insurance and non-modifiable factors will help us to preserve or improve quality of life of older people.

DETECTING PRE-FRAILTY STATUS: COMPARISON OF CLINICAL JUDGMENTS AND THE PAULSON LICHTENBERG FRAILTY INDEX.

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Nearly 50% of U.S. elders are prefrail and at risk for frailty. Identifying prefrail elders and escalating care could attenuate frailty progression. Screening tools are seldom used in practice. Thus, clinical judgment may be a realistic way to ensure widespread frailty screening. No studies, however, have assessed the validity of clinicians’ judgment in identifying prefrail elders. This study explored the level of agreement between clinical judgments of frailty status and status categorizations made using the validated Paulson Lichtenberg Frailty Index (PLFI). Older Blacks (n = 202) recruited from a primary care clinic were first categorized as healthy, pre-frail, or frail using the PLFI. Next, geriatric physicians and nurses categorized participants into one of the same categories based on clinical