tryptophan and downstream metabolites via LC-MS. PFC was evaluated for mRNA expression of select inflammatory cytokines. PCoA revealed that groups differed in the overall fecal microbiota community structure as determined by Unweighted UniFrac. Indices of alpha-diversity, including richness and phylogenetic diversity, displayed significant group differences—with the most dramatic effects observed in the 3-times/week group. Compared to control, serum serotonin and 2-Picolinic Acid were significantly increased in the 3-times/week group. The 3-times/week regimen also significantly reduced COX2, IL1β, and TNFα mRNA expression, and 7-times/week reduced COX2 and IL1β expression in PFC. Therefore, we conclude that short-term treatment with Ang(1-7) LP dose-dependently benefits the gut-brain axis in aged rats, with 3-times/week appearing to be the optimal dosing regimen.

**GAIT UNSTEADINESS AS AN INDICATOR OF COGNITIVE STATUS IN INDIVIDUALS WITH PERIPHERAL NEUROPATHY**

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Neuropathic individuals are at risk of falls, however potential impact of cognitive impairment in neuropathic individuals is not well-understood. Since cognitive impairment is considered an independent risk factor for falls, knowing its potential, additional impact may help better understand underlying mechanism of risk of falls in neuropathic individuals. We aimed to investigate stride-to-stride variability in neuropathic individuals with cognitive impairment (NP-Cog-Impaired) during normal and dual-task walking. Neuropathic symptoms and cognitive status was measured using maximum vibration perception threshold (VPTmax) in the feet and the Montreal Cognitive Assessment (MoCA), respectively. We analyzed data from 19 NP-Cog-Impaired (8 men; 68.5±9.1 years; 29.0±6.2 kg/m2; VPTmax=27.2±12.1 volts; MoCA=19.6±2.4) and 25 NP-Cog-Intact (15 men; 66.5±9.1 years; 31.3±5.9 kg/m2; VPTmax=26.3±12.7 volts; MoCA=25.6±1.6). We collected movement data using five inertial sensors (LEGysTM, BioSensics LLC, Watertown, MA) attached on the shanks, thighs and lower back. We previously validated algorithm to calculate coefficient of variations (CV) of stride velocity and stride length. CV of stride velocity and stride length were significantly greater for the NP-Cog-Impaired group (11.07±5.22% and 7.31±3.20%, respectively) than for the NP-Cog-Intact group (7.31±3.20% and 4.81±2.80%, respectively) for dual-task walking but not for normal walking. Between normal and dual-task walking, CV of stride velocity and stride length increased 43.2% (significantly) and 46.4% (marginally), respectively, from normal walking to dual-task walking for the NP-Cog-Impaired group but not for the NP-Cog-Intact group. Results suggest that cognitive impairment may be an additional risk factor of falls in neuropathic individuals.

**PREDICTIONS OF RISK TOLERANCE ACROSS DISEASE SCENARIOS AMONG OLDER ADULTS**

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Advance care planning requires older adults to contemplate what kind of medical care they would prefer if faced with serious illness. Those decisions involve weighing risks of medical treatments with quality of life. The purpose of this project was to explore older adults’ tolerance for risk in medical treatment scenarios. Thirty-three adults over age 60 (mean age = 74.9, SD = 8.9) were presented with four medical scenarios reflecting increasingly severe diseases (urinary incontinence, kidney failure, dysphagia, Alzheimer disease). For each, they were asked whether they would accept a treatment with increasing risk of death (5%, 50%, 95%). Participants also recorded demographic characteristics and completed a physical and mental health measure. Older adults were more willing to accept hypothetical treatments with lower risk of death (Cochran’s Q = 27.8 - 39.0, p’s < .001), and they were more willing to accept treatments when faced with more severe diseases (Cochran’s Q = 8.7 - 29.8, p’s < .05). There were no significant associations between risk tolerance and demographic and health characteristics. These results suggest that older adults are diverse in their willingness to accept medical treatments risks, at least when presented with hypothetical medical scenarios. Medical professionals and family members who collaborate with older adults should be aware of this diversity of preferences and check assumptions based in demographic and health characteristics. Given these nuances, interventions to promote communication about medical preferences are essential to patient-centered advance care planning and medical decision making.

**COMMUNITY-BASED SERVICES AND OLDER ADULTS: A COMBINATION IN MENTAL HEALTH PROMOTION**

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Mental health promotion among older adults has been considered an important goal by the World Health Organization (WHO, 2017). Mental health has been understood as not necessarily the absence of mental illness, but in fact, points on a continuum that although are not mutually exclusive, and it may intersect at times (Cowen, 1991; Keyes & Westerhof, 2012). With such complex health component, medical practices—although extremely critical in many cases—are often one factor of in the equation. Other practices, such as positive relationships among individuals and measures to tackle isolation are relevant and successful when planning practice for mental health promotion (Wister & McPherson 2014; Newall & Menec, 2019). A study done at a community-based seniors service in Vancouver – Canada shows that these spaces are considered a critical resource for visible minority older adults. Two focus groups were conducted at a community-based senior service with visible minority older adults between ages 55 to 80 years old. Results show that visible minority older adults strongly rely on this sector to maintain the connection with the society, and to the services provided in the wider community. Community-based seniors service provide opportunities for social inclusion and interactions, learning new things, and it has an inverse association with feeling isolated and lonely at home—a constant issue stated in the research. These findings
indicate the critical role of this sector in ameliorating and promoting the mental health of visible minority older adults.

ADVANCE CARE PLANNING COMMUNICATION: AN INTERACTIVE WORKSHOP WITH ROLE-PLAY FOR STUDENTS AND PRIMARY CLINICIANS
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There is a need for increased clinician training on advance care planning (ACP). Common barriers to ACP include perceived lack of confidence, skills, and knowledge necessary to engage in these discussions. Furthermore, many clinicians feel inadequately trained in prognostication. There is evidence that multimodality curricula are effective in teaching ACP, and may be simultaneously targeted to trainees and practicing clinicians with success. We developed a 3-hour workshop incorporating lecture, patient-oriented decision aids, prognostication tools, small group discussion, and case-based role-play to communicate a values-based approach to ACP. Cases included discussion of care goals a patient with severe COPD and one with mild cognitive impairment. The workshop was delivered to 4th year medical students, then adapted in two primary care clinics. In the clinics, we added an interprofessional case applying ACP to management of dental pain in advanced dementia. We evaluated the workshops using pre-post surveys. 34 medical students and 14 primary care providers participated. Self-reported knowledge and comfort with ACP significantly improved; attitudes toward ACP were strongly positive both before and after. The workshop was well received. On a seven-point Likert scale, (1=Unacceptable, 7=Outstanding), the median overall rating was 6 (“Excellent”). In conclusion, we developed an ACP workshop applicable to both students and primary clinicians. We saw improvements in self-reported knowledge and comfort with ACP, though long-term effects were not studied. Participants found the role-play especially valuable. Most modifications for primary care clinics focused on duration rather than content. Future directions include expanding the interprofessional workshop content.

HEALTHCARE ENCOUNTERS AS PREDICTORS OF DEATH ANXIETY IN OLDER ADULTS
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Literature suggests 10–15% of Americans experience death anxiety (DA). While DA is a response to heightened death awareness, research has not fully explored the link between DA and healthcare utilization. 2012 Health and Retirement Study data were used. Three binary logistic regressions analyzed hospitalization, ER admission, nursing facility placement, and outpatient visits’ abilities to predict DA (0 = “none,” 1 = “at least some”) over the past week. Model 1 included demographics and all four types of healthcare encounters. One item from the Beck Anxiety Inventory assessed DA. Most subjects in the sample (N = 7,185) were married (n = 4,302), and White (n = 5,479). Fifteen percent reported ER admissions, 24.6% reported hospitalizations, 1.1% reported nursing facility placements, and 91.5% reported outpatient visits. Regression results from each model showed nursing facility placement and outpatient visits to be statistically significant predictors of DA across all models (OR ranges = 2.23–2.38 and 1.23–1.25 respectively, p < .05 in all models). Hospitalization predicted DA in Models 1 (OR = 1.30, p = .004) and 2 (OR = 1.46, p < .001). Model 3 showed ER admission (OR = 1.52, p < .001) predicted DA. Results from each model indicated individuals who experienced nursing facility placements exhibited double the odds of experiencing DA, compared to those who did not. Outpatient visits were the weakest predictor of DA in each model. DA’s association with healthcare utilization provides implications for providers. Future research should explore the relation between DA and health outcomes.

NEUROTICISM PREDICTS INFORMANT-REPORTED COGNITIVE DECLINE THROUGH HEALTH BEHAVIORS
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Our current study attempts to better understand the relationship between personality and cognitive decline. In this study, we analyzed whether health behaviors act as mediating variables for the relationship between personality and cognitive decline. Additionally, we were interested to see how personality influences different health behaviors, and which health behaviors in particular are predictive of cognitive decline. In addition to analyzing the composite score of health behaviors in relation to personality and cognitive decline, we analyzed each of its four components (wellness maintenance, accident control, traffic risk, and substance abuse; Vickers, Conway & Hervig, 1990). To measure cognitive decline, we used the Ascertain Dementia Eight Item Scale, an informant-report screening measure. Personality has consistently been linked to cognitive decline (Curtis, Windsor & Soubelet, 2015; Chapman, Duberstein, Tindle, Sink, Robbins, Tancredi & Franks, 2013; Low, Harrison & Lackersteen, 2013), but has not yet been analyzed with an informant report measure. Informant-report may be more reliable than self-report when measuring cognitive decline because participants who exhibit cognitive impairment may not be equipped or willing to report about their own cognitive ability. We found that neuroticism significantly predicted informant-reported cognitive decline and that this relationship was mediated by health behaviors, specifically, wellness maintenance. Wellness maintenance was the only category of health behavior that predicted informant-reported cognitive decline. Surprisingly, conscientiousness was unrelated to informant-reported cognitive decline as were extraversion, agreeableness, and openness to experience.

OLDER AND MORE MINDFUL? ASSOCIATIONS OF MINDFULNESS CHARACTERISTICS AND WELL-BEING VARY WITH AGE
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Research examining how mindfulness confers benefits for well-being is in its infancy. Furthermore, few studies have considered the positive effects of mindfulness on psychological functioning from a lifespan perspective. The present study aimed to examine a recently proposed model of mindfulness