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Findings that older adults are not sufficiently physically active are largely based on cross-sectional comparisons with a narrow definition of physical activity. Using data from the Longitudinal Aging Study Amsterdam (n=2,486, age range 54–104 years, M=72, SD=9.08; 50% women), we examined how the proportional contribution of eight activity domains (e.g., structured sports, household work, walking for transportation) to total activity time changed with increasing age and investigated the role of sociodemographic, psychological, and environmental factors including gender, self-efficacy, and urbanization. Low-intensity activities for mastering daily life (e.g., light housework) increased in importance with age; they were affected by sociodemographics and health. Higher intensity activities (e.g., heavy housework) tended to decline; they were influenced by sociodemographics. Other activities (e.g., structured sports) remained stable at low frequencies; they were shaped by sociodemographics and external factors. Differentiating activities by purpose may contribute to better understanding age-related trajectories and identifying relevant predictors.

LIKABLE PHYSICAL ACTIVITIES TO CHOOSE WHEN GIVEN THE OPPORTUNITY: PREFERENCES FOR PHYSICAL ACTIVITY IN OLDER ADULTS

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Physical activity (PA) is associated with healthy aging, yet many older adults remain physically inactive. According to the socio-culturally targeted approach to PA promotion, matching the program components to an individual's preferences would contribute to maximize program engagement and PA participation. The aim of this research was to identify preferences for PA among older adults. A systematic review was conducted (Study 1), and findings from 21 studies (sample mean age ≥ 65 years) were qualitatively summarized. To alleviate measurement issues detected in reviewed studies, 77 volunteers (mean age = 75.9 years) were surveyed using non-constrained and reliable preferences scales (Study 2). Taking together, findings indicate that: walking followed by gardening/yardwork are the preferred type of PA, older adults prefer low-intensity over high-intensity PA, and there is high variability among individuals regarding the preferred social context. Program developers should consider walkability in their efforts to promote PA in older adults.

CADENCE (STEPS/MIN): HOW FAST IS FAST ENOUGH FOR OLDER ADULTS?

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Cadence (steps/minute) is an emerging proxy-indicator of ambulatory metabolic intensity. 100 steps/minute is a consistent threshold associated with absolutely-defined moderate intensity (i.e., 3 metabolic equivalents or METs; 1 MET=3.5 mL O2/kg/min) in adults up to 60 years of age, but its stability in older adults is not clear. Conflicting findings indicate older adults attain moderate intensity at lower, but also higher, cadences. Differences may be due to relative vs. absolute definitions of intensity with age. We present the preliminary results from CADENCE-Adults, an NIH-funded study evaluating cadence and intensity across the adult lifespan up to 85 years of age.

THE LONG VIEW: COMPARING OUTCOMES OF CLASS- AND HOME-BASED PHYSICAL ACTIVITY PROGRAMS FOUR YEARS LATER

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Both class- and home-based (CB; HB) physical activity programs are effective in increasing functional performance, physical fitness and other health outcomes in older adults. Direct comparisons of program effectiveness have been equivocal and few have examined outcomes beyond the 12-month mark. 50+ in motion was a randomized clinical trial comparing the effectiveness of a CB and HB physical activity program for sedentary older adults with chronic health conditions. The intervention consisted of a 3-month intensive phase and a 9-month follow-up phase. Data were collected from 172 participants at baseline, 3-, 6-, 12-months, and then annually for a total of 48 months. Outcomes included cardiovascular fitness, functional performance, body composition, quality of life, and health services utilization. In both programs, improvements in most outcomes were sustained beyond 12-months with some extended through the

entire follow-up period. There were no differences in health services variables between the programs until the final year.

SESSION 2495 (PAPER)

LONG TERM CARE

WHAT DOES EXPLAIN THE REGIONAL VARIATION IN LIVING AT HOME OR IN INSTITUTION WHEN DEPENDENT IN FRANCE?

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Population aging raises the question of the long-term care (LTC) organization for the dependent elderly. In France, "in home" LTC is promoted to meet both individual and policy (partly cost-related) preferences. However, LTC management is decentralized at a county level inducing variations in the type of LTC supply, partly due to (unequal) local resources. This article aims to identify county variations in living in institution for dependent elderly people (60+) and how much different LTC supply contributes to these variations. We used different data sources to estimate the probability of living in institution versus at when having disabilities (i.e. bathing difficulties): survey EHPA 2015 for population living in institution (n=308,312) and survey VQS 2014 for population living at home (n=161,419). We complemented these sources with data on contextual LTC supply and socioeconomic status (SES) indicators. Multilevel regression models are computed to assess how much of the county variance of institutionalization decreases when controlling for in LTC supply and SES and identify the share of variance explained by the differences in LTC supply and SES. We found that county variation explained 21% of the institutionalization risk: of which 40% is explained by SES contextual differences and 7% by difference in the LTC supply. Further researches are needed to determine whether these differences reflect county's unequal resources to supply LTC or county's different preferences.

THE EFFECT OF PRIMARY CAREGIVERS' EMPLOYMENT STATUS ON OLDER PEOPLE'S CARE RECEIPT FROM DIFFERENT SOURCES

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Social gerontologists have predicted that increased female employment would adversely affect the ability of disabled older people to rely on unpaid family caregivers. This paper is one of only a few that focuses on not only whether disabled older people receive fewer hours of help from employed primary caregivers but also whether other members of the care network compensate for any reduction in primary caregiver hours. We conduct a pooled cross-sectional analysis of data on 2,268 older people and their primary caregivers from the National Study of Caregiving I and II, which was administered as part of rounds 1 and 5 of the National Health and Aging Trends Study. Consistent with previous studies, we find that employed primary caregivers provide fewer hours of help per week compared to non-working primary caregivers (27 versus 40 hours, $p < .01$). Secondary caregivers' hours do not change in response to the employment status of primary caregivers. However, older people with an employed primary caregiver make greater use of paid help compared to older people with a non-working primary caregiver (8 versus 5 hours, $p < .01$). Therefore, while older people partially compensate for the reduction in hours from employed primary caregivers through greater use of paid help, older people with an employed primary caregiver still receive fewer total hours of help overall (-10 hours, $p < .01$). We also find that the compensatory effect of paid help is greater among older people with 2+ ADLs, dementia, and higher incomes.

CHARACTERIZING STAFF INTERACTIONS IN A SAMPLE OF HIGH PERFORMING NURSING HOMES

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Increasing evidence indicates nursing home staff interactions with residents and each other contribute to care quality. We characterized interaction in a sample of top performing person-centered care (PCC) adopters in the Veterans Administration (VA) system of 134 Community Living Centers (CLCs– i.e., nursing homes). We identified 8 top-performing CLCs using a combination of quality and PCC indices. At these 8, staff participated in a validated survey of relational coordination. Researchers also conducted structured observations of staff and resident behavior in public areas. Analyses were descriptive. 392 staff responded to the survey. Researchers conducted 2,459 observations. Across all CLCs, staff reported the quality of their interactions within (WI) their workgroup consistently lower than the quality of their interactions between (BW) their and other workgroups. BW ratings: 24% strong, 34% moderate, 42% weak. WI ratings: 92% weak. Strong ratings varied by workgroup type and by WI and BW. Nursing was more likely to receive strong ratings than other workgroups but less likely to assign strong ratings to other groups. 31% of observations were of staff performing direct resident care while communicating with the resident and 39% were of staff having no communication with the resident during care. Results in this top-performing sample indicate potential room for continued improvement. Given our findings of rather low relational coordination and interaction quality, quality improvement interventions directly targeting staff communication and staff-resident interaction might represent opportunities for positive impact not only in high PCC performers but across the PCC performance spectrum.

ENHANCING STAFF-RESIDENT INTERACTIONS THROUGH A FRONTLINE STAFF QUALITY IMPROVEMENT INTERVENTION

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