MARITAL STATUS AND GENDER DIFFERENCES IN END-OF-LIFE PLANNING

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Less than half of older adults make formal preparations to control difficult life transitions, yet planning can mitigate negative outcomes that accompany changes. To better understand multiple forms of end-of-life planning behaviors and the effect of demographic characteristics, we use data from the Understanding America Study (N=1812; aged 60+). We explored gender and marital differences in whether respondents created a will, living will, or declared a durable power of attorney for health care (DPOAHC), and who was chosen as DPOAHC (i.e., spouse, child, other relative). T-tests determined no significant gender differences in declaring a DPOAHC, creating a will, or living will. An analysis of variance ($F=13.422$, $df=3$, $p<0.001$) found married respondents more likely to declare a DPOAHC than separated/divorced ($p<0.001$) and never married respondents ($p=0.002$). Divorced respondents were less likely to declare a DPOAHC compared to widowed respondents ($p<0.001$) and widowed respondents were more likely compared to never married respondents ($p=0.001$). Additional analyses found the same pattern in who created a will or living will. A follow-up analysis of variance found no gender differences within marital status categories (i.e., married men versus married women). Overall, respondents who were never married were less likely to have prepared any forms of end-of-life planning. These results highlight the importance of having close relationships on the level of preparedness for end-of-life planning. Additional implications include increasing awareness about end-of-life planning for more vulnerable audiences. Future analyses will integrate findings regarding financial DPOAHC and examine other socio-demographic characteristics, such as education and race.

PREDICTORS OF CHANGE IN OSTEOPOROSIS KNOWLEDGE, HEALTH BELIEFS, AND SELF-EFFICACY AFTER AN EDUCATION INTERVENTION

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Education interventions that increase osteoporosis knowledge and address health beliefs and self-efficacy help older adults make informed decisions to prevent and manage the disease. The aim of this study was to determine if clinical risk factors for osteoporosis moderate the effect of a multifaceted education intervention on osteoporosis knowledge, health beliefs, and self-efficacy. Patients 50 years and older with no prior diagnosis of or treatment for osteoporosis were referred by their primary care provider for bone mineral density testing by DXA and randomized to an osteoporosis education intervention group (n = 102) or usual care group (n = 101). Demographic and health history questionnaires, and validated tools to assess osteoporosis knowledge, health beliefs and self-efficacy were completed at baseline and 6-month follow-up. Results of the linear mixed-effects model showed a significant interaction with younger age ($p=.024$) on self-efficacy among patients in the intervention group compared to the usual care group. Patients with higher BMI had greater perceived health motivation ($p=.026$) in the intervention group. Compared to the usual care group, patients in the intervention group with higher vitamin D intake had greater perceived exercise ($p=.020$) and calcium benefits ($p=.012$) and those with a family history of osteoporosis had greater perceived susceptibility to osteoporosis ($p=.045$). By understanding the key factors that predict change in knowledge, health beliefs and self-efficacy after an education intervention compared to usual care, we can better tailor interventions to enhance prevention and management of osteoporosis.

SOCIODEMOGRAPHIC AND MARITAL DIFFERENCES IN SPOUSAL INVOLVEMENT IN A PARTNER'S DIABETES DIET

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Spouses are commonly involved in their partners' diabetes management by supporting and regulating (i.e., controlling) their diet. Little is known, however, about what characteristics are associated with how and how often spouses are involved in this context. This study examined whether sociodemographic and marital characteristics helped explain some of the variability in diet-related spousal involvement in promoting a partner's adherence to a diabetes diet; specifically, whether gender, race/ethnicity, marital quality, and marital length were related to the frequency of spousal engagement in health-related social support and two types of health-related social control. Gender and race/ethnicity were examined as exploratory moderators of the associations between marital characteristics and spousal involvement. Data from two different data sets of older adults (55+ years) whose partners had type 2 diabetes were examined among four racial/ethnic groups (study 1 n = 205; study 2 n = 155). Regression analyses that controlled for patients' co-morbid health conditions revealed gender and racial/ethnic differences in the frequency of spousal involvement. In addition, marital quality was related to the frequency of support and positive forms of social control among most participants, particularly African American spouses. No associations between marital length and any type of spousal involvement were found, nor were there any gender differences in any of these associations. These findings provide insight into the importance of sociodemographic characteristics and marital quality in understanding spousal involvement in a partner's diabetes management.

STEP UP: AN EVALUATION OF QUESTION-BEHAVIOR EFFECTS IN DIABETES FOOTCARE IN MIDDLE-AGED AND OLDER ADULTS

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