adapting to patient's lifestyle), process-focused (e.g., patient education on polypharmacy), and medication-focused (e.g., tapering). It is clear that many of the primary care providers who treat a larger number of older adults are aware of the importance of deprescribing PIMs. However, deprescribing in a busy primary-care setting is challenging. Findings detailing providers' perceptions of facilitators and strategies for deprescribing can guide future interventions and target support to reduce the risk of harm from PIMs in older adults.

THE CONTRIBUTION OF EIGHT MODIFIABLE RISK FACTORS TO DEMENTIA PREVALENCE IN JAMAICA

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The number and proportion of dementia cases in Jamaica attributable to eight modifiable lifestyle factors was calculated using factor analysis in Stata and Levin's Attributable Risk formula (hypertension, diabetes mellitus, depression, low educational attainment, smoking, overweight, obesity and vision problems). Four sources of data were used: (1) risk factor prevalence data were obtained from the Jamaica Health and Lifestyle Survey, 2008, (2) relative risk data were sourced from published meta-analyses, (3) factor analysis in Stata version 15 was performed to estimate shared variance among risk factors utilising data from the Health and Social Status of Older Persons in Jamaica Study and, (4) estimated prevalence of dementia in Jamaica in 2012 was obtained from a 2018 publication by Shearer et al. Obesity was found to be responsible for the largest proportion of dementia cases (13.94%; 2508 cases) followed by hypertension (10.64%; 1917 cases), low educational attainment (7.21%; 1299 cases), overweight (6.42%; 1156 cases), smoking (3.90%; 702 cases), diabetes (3.38%; 608 cases), depression (1.00%; 181 cases) and impaired vision (0.002%; 34 cases%). Using this largely theoretical model, the eight factors examined account for approximately 46.0% of dementia cases. Dementia risk reduction programs that target even one of these factors has the potential to result in significant reduction in future dementia prevalence as they are all interrelated. In future work, as these data become available, the contribution of mid-life obesity, mid-life hypertension and physical inactivity will also be taken into consideration.

UNDIAGNOSED DIABETES: IDENTIFYING THE COMMUNITY PATHS TO TYPE 2 DIABETES DIAGNOSTIC TESTING

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Over seven million U.S. adults are estimated to have undiagnosed diabetes and are at heightened risk of diabetes complications and poorer long-term glycemic control. Key to addressing undiagnosed diabetes is identifying how persons encounter diabetes testing in everyday life and the contextual factors that lead to consulting a health care provider. As part of the NIA-funded Subjective Experience of Diabetes Study we examined the pathways through which community-living African-American and non-Hispanic White older adults with type 2 diabetes (T2D) (N=75) received their T2D diagnosis. Systematic, thematic analyses using ATLAS.ti reveals three primary routes to diabetes diagnosis: diagnosis through continuity of primary care, diagnosis through happenstance testing, and diagnosis following the exacerbation of symptoms. While diagnosis as part of routine care was the least reported (N=13), participants' accounts suggest diagnosis in primary care validates the patient-provider relationship and provides an occasion to calmly establish a treatment plan. More frequently, however, diagnosis occurs through fortuitous encounters with glucose tests, e.g., through work or community research projects (N=15) or after symptoms become alarming and disrupt daily life (N=47). Participants' experiences in these latter two categories reveal the critical role of insurance and social prompts in the decision to consult a clinical provider regarding symptoms. At the same time, the abundance of over-the-counter therapies treating conditions commonly found early in the emergence of diabetes can delay clinical follow up. These findings highlight the importance of social prompts and community-based testing in the fight to reduce undiagnosed diabetes.

WEIGHT CHANGE AND ALL-CAUSE MORTALITY IN LATER LIFE: FINDINGS FROM THE NATIONAL SURVEY OF THE JAPANESE ELDERLY

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Recent studies predominantly in Western populations suggest that both weight gain and weight loss are associated with increased mortality risk in old age. However, evidence on this topic in Asian populations remains sparse. We examined the association between weight change and all-cause mortality in a nationally-representative sample of community-dwelling older Japanese. Data came from the National Survey of the Japanese Elderly (N = 4,869, age ≥ 60 years). Participants were followed for up to 30 years. Short-term (3 years) and medium-term (6 years) weight changes were classified as "loss ≥ 5%," "loss 2.5%–4.9%," "stable," "gain 2.5%–4.9%," and "gain ≥ 5%." Cox proportional hazards models were used to assess the relative (stable weight as reference) mortality risk associated with weight change categories. Short-term weight loss ≥ 5% was associated with higher mortality compared to the stable category, after adjusting for sociodemographic factors, health behaviors, and health conditions (hazard ratio = 1.36; 95% confidence interval = 1.22–1.51). The other weight change categories had no significant association with mortality. This was observed both among males and females. Moreover, the same pattern of results was observed when we used the medium-term weight change indicator. In conclusion, we found that both short- and medium-term weight loss greater than 5% increased the risk of dying among older Japanese; however, other types of weight change did not. This finding could inform clinical and public health approaches to body-weight management aimed to improve the health and survival of older adults, particularly in Asian populations.