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Community and academic partners in rural West Alabama collaborated to increase healthcare access among rural mid-life and older adults. This interdisciplinary healthcare team utilized a mobile unit to provide health screenings and behavioral assessments. The establishment of trust and respect early in the partnership provided a foundation for community engagement and played an intricate part in effectively mobilizing the unit. Providing services via the mobile unit served as an effective way to address issues related to access to care and availability of healthcare providers. It also presented an opportunity for the detection and prevention of mental and medical illness that can be easily assessed by screening measures. Furthermore, when the medical issues were linked to health outcomes, such as metabolic syndrome (MSX) and cognitive impairment, the mobile unit helped promote both physical and mental well-being among rural mid-life and older adults. Descriptive analyses and analysis of variances (ANOVA) were performed to assess the effect of gender, race, and community on the number of MSX risk factors. Results of a three-way ANOVA revealed a significant interaction between gender, age and community on the number of risk factors; post hoc analyses indicated rural communities with lower social economic status (SES) and predominantly African American residents were at greater risk for developing MSX compared to communities with higher SES. The mobile unit provided a great way to engage mid-life and older adults while offering preventive health screenings in rural communities.

CONTEXTUALIZATION OF SURVEY DATA: WHAT DO WE GAIN AND DOES IT MATTER?

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Survey research designs that integrate contextual data have become more prevalent in recent decades, presumably to enable a more refined focus on the person as the unit of analysis and a greater emphasis on inter-individual differences due to social forces and contextual conditions. This article reviews varied approaches to contextualizing survey data and demonstrates the value of two integrative approaches for the study of human development and aging—the use of interviewer ratings and neighborhood information (measured via census tracts). The utility of an integrative approach is illustrated with data from the Health and Retirement Study, revealing what is gained by using a contextualized approach and how substantive conclusions may be misdirected when contextual factors are neglected. Neighborhood disorder, measured by respondent and interviewer ratings, as well as geocoded neighborhood socioeconomic data were used to predict disability and depressive symptoms among older adults. Results indicate that racial and ethnic differences in functional limitations and depressive symptoms may be overestimated when failing to include contextual neighborhood characteristics. To enhance the predictive validity of

survey data, investigators should consider meaningful contextual data for specific research questions.

PATTERNS OF MISSING DATA AT THE END-OF-LIFE: USING LINKED MORTALITY DATA TO EXAMINE BIAS IN PANEL DATA

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Panel surveys for older adults would ideally contain data up to the end of participants' lives. This allows analysis of key changes, including increasing health and social care use, that more commonly occur in the final years of life. However, all panel surveys suffer from attrition across waves, including non-response. Missing data analysis tends to categorise participants as either participating, missing or dead. Using linked mortality data within the English Longitudinal Study of Ageing (ELSA) a person's death is recorded even if they have missed several waves of data collection. This enables us to determine not just if data is missing but how much data is missing before end-of-life. Three research questions are addressed: 1) For those who have died between waves 1 and 5 of ELSA, how many waves were missing prior to death? 2) What is the average amount of missing data at end-of-life? 3) Is the amount of missing data randomly distributed? Specifically does cause of death relate to how much data is missing? Analysis indicates that almost 30% of those who have died have 1, 2 or 3 waves missing prior to death and the amount of missing data is not random. Using multistate life tables, it is demonstrated that cause of death relates to the chances of having more waves missing. In conclusion, those with declining function over a long period of time are more likely to have more waves missing. These patterns of missingness should be considered when analysing data from older populations.

RETENTION OF PARTICIPANTS IN LONGITUDINAL ALZHEIMER'S DISEASE STUDIES: WHO STAYS?

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A high attrition rate is a major barrier in conducting longitudinal studies. The aim of this retrospective cohort study is to explore the traits of participants in longitudinal Alzheimer Disease (AD) studies in order to investigate retention barriers and facilitators. To determine the relationships of baseline demographics, cognitive status (The mini-mental state examination), AD biomarkers (elevated cerebral amyloid-beta (A β) burden measured by positron emission tomography), and the retention rate in an AD research, Pearson correlation, Welch's t test and chi-square were conducted. A retention score was calculated by dividing the number of missed appointments by the number of scheduled appointments. There were 660 participants (age mean = 74.9 $\pm$ 9.2; 60.2% female; 85% Caucasian) who have records of clinical assessments in our study; 71 participants (89.24%) who have a retention score lower than 70% were selected in low retention group for comparison. The results showed that older age ($r=.599$, $p<.01$), being male ($\chi^2 = 4.53$, $p=0.03$), lower cognitive status ($t= 6.60$, $p=0.01$), and higher A β burden are significantly related to higher retention rate. The result of this study provided an initial exploration of