

1,349

PARTICIPANTS
ACROSS 11
SITES

73%

REPORTED HIGH
MOTIVATION
(RATING 4-5)

82%

SELF-REPORTED
BEHAVIOR
CHANGE

4

TOPICS: SLEEP ·
MINDFULNESS ·
NUTRITION ·
FITNESS

2yr

STUDY PERIOD
JAN 2024-DEC
2025

BACKGROUND & PURPOSE

The Healthy Aging Challenge

40% of U.S. adults 65+ experience age-associated memory difficulties — expected to double by 2060. Modifiable lifestyle behaviors are among the most powerful tools for mitigating ADRD risk, yet translating evidence into population-level behavior change remains a persistent challenge.

Do community education programs motivate older adults to change health behavior?

YES — across all demographics.

THEORETICAL FRAMEWORK — HEALTH BELIEF MODEL

**PERCEIVED SUSCEPTIBILITY**
Personal risk of cognitive decline

**PERCEIVED SEVERITY**
Fear of dependency & loss of autonomy

**PERCEIVED BENEFITS**
Practical, actionable strategies

**SELF-EFFICACY**
Incremental, manageable changes

**CUES TO ACTION**
Lecture sessions as immediate behavioral triggers

METHODS

Study Design

Mixed-methods, non-experimental design. Post-lecture 13-item questionnaire at 11 South Florida community sites. Five focus groups analyzed via traditional thematic analysis and AI-assisted coding (Claude 3.5 Sonnet) against HBM constructs.

85.9% Female

85.4% Age 65+

88.3% Retired

86.3% College Ed.

51.5% White

24.4% Latin/Latinx

10.1% Black

POLICY IMPLICATIONS

What This Means for Practice

**SUSTAINED PUBLIC FUNDING**
Evidence supports investment in community health education infrastructure — senior centers, libraries, and community organizations — as cost-effective platforms for scalable preventive programming.

**HEALTH EQUITY STRATEGY**
Strong engagement among Black and Latin/Latinx participants demonstrates that when structural barriers are reduced, motivation is high. Culturally accessible programs can meaningfully reduce preventive care disparities.

**SCALABLE MODEL**
Brief lunch-and-learn formats are low-cost and replicable. Policymakers should consider integrating community-based education into aging policy frameworks alongside clinical prevention services.

RESULTS — OVERALL MOTIVATION & BEHAVIOR CHANGE

73%

73% high motivation
(rating 4-5)
46.5% rated "Very much"

82%

82% behavior change
(Q13=Yes, n=665)
After prior sessions

Q1 × Q4 — PRIOR KNOWLEDGE × MOTIVATION TO CHANGE
Did knowing the topic beforehand affect motivation?

Rating 1 (low)	53%
Rating 2	50%
Rating 3	48%
Rating 4	51%
Rating 5 (high)	54%

% reporting highest motivation (Q4=5) by prior-knowledge level (n=1,305)

→ Flat pattern: prior knowledge does NOT predict motivation

Q2 × Q4 — TOPIC INTEREST × MOTIVATION TO CHANGE
Did interest in the lecture topic drive motivation?

Rating 1 (low)	17%
Rating 2	24%
Rating 3	38%
Rating 4	52%
Rating 5 (high)	65%

% reporting highest motivation (Q4=5) by interest level (n=1,302)

→ Strong gradient: higher interest = higher motivation

Q3 × Q4 — KNOWLEDGE GAINED × MOTIVATION TO CHANGE
Did perceived learning during the lecture drive motivation?

Rating 1 (low)	7%
Rating 2	18%
Rating 3	34%
Rating 4	55%
Rating 5 (high)	70%

% reporting highest motivation (Q4=5) by perceived knowledge gained (n=1,305)

→ Strongest predictor: perceived learning drives motivation most

DEMOGRAPHIC VARIATION — % RATING "VERY MUCH" (Q4=5)
High motivation across all groups; variation reflects structural access to health education, not inherent differences

Black/Afr. Am.	74%
Non-retired	60%
Latin/Latinx	57%
Under 65	57%
Asian	49%
Age 65+	45%
White/Caucasi	36%

Poster # 4035

QUALITATIVE FINDINGS

Why Participants Were Motivated

5 focus groups · 16 mega-codes mapped to HBM constructs via traditional + AI-assisted coding

**FEAR OF DEPENDENCY**
"I'm afraid of losing my independence... not being able to take care of myself." Fear of institutional care and becoming a burden to family — deeply personal perceived severity beyond clinical risk.

**LECTURES AS CUES TO ACTION**
"I already made changes after the sleep lecture." Sessions as immediate behavioral triggers. Peer interaction reinforced motivation through social modeling.

**SELF-EFFICACY THROUGH "THE WHY"**
Understanding rationale behind recommendations strengthened perceived control. Incremental framing reduced barriers. Group setting amplified confidence and sustained intent.

"When you understand why sleep matters for your brain — not just that it does — you actually change something that night."
— Focus group participant, Sleep hygiene session

THREE MECHANISMS DROVE OUTCOMES

1

Perceived severity tied to independence & family burden created strong motivational readiness

2

Evidence-based lectures served as immediate cues to action, especially for sleep hygiene

3

Incremental framing + group delivery activated self-efficacy and sustained intent

LIMITATIONS

Self-selected sample may bias toward health engagement. Survey data collected immediately post-lecture; sustained change not assessed. Self-reported outcomes subject to social desirability bias. Some demographic subgroups small, limiting inference. Focus groups unequal across lecture topics.

CONCLUSIONS

Community-based health education **does motivate older adults to change health behavior** — 73% high motivation, 82% behavior change across all demographics. Prior knowledge does not predict outcomes; **interest and perceived learning do**. High engagement among Black and Latin/Latinx participants underscores the equity potential of accessible community education.