individuals with Mild Cognitive Impairment (MCI). The lack of social connectedness could increase the chances of these individuals progressing to dementia.

Methods: We cross-sectionally assessed social networking among 122 subjects with MCI and 2403 cognitively healthy subjects, aged 45 years and above, from the Srinivaspura Aging, NeuroSenescence and COGnition (SANSCOG) study cohort in rural southern India. Cohen's Social Network Index (SNI) was used to assess social networking, wherein three dimensions are assessed: network diversity, number of people in social network, and number of embedded networks. The diagnosis of MCI was made using the Clinical Dementia Rating (CDR) instrument. This is an extensively validated 5-point scale, wherein six cognitive and functional domains are assessed: Memory, Orientation, Judgment & Problem Solving, Community Affairs, Home & Hobbies, and Personal Care. The overall CDR score of '0' was interpreted as cognitively normal and CDR score of '0.5' as MCI. The SNI dimension scores were compared between subjects with MCI and cognitively healthy subjects using t-test and a p-value of <0.05 was considered significant.

Results: The mean scores of all three SNI domains were significantly lower in MCI compared to cognitively healthy subjects: network diversity (5.30 ± 1.54 vs. 5.94 ± 1.60, $p < 0.001$), number of people in social network (18.4 ± 8.61 vs. 20.3 ± 8.87, $p = 0.023$), and number of embedded networks (1.80 ± 1.26 vs. 2.03 ± 1.14, $p = 0.038$).

Conclusion: Aging rural Indians with Mild Cognitive Impairment (MCI) have poorer social networks than their cognitively normal counterparts. Hence, social connectedness should be routinely evaluated in individuals with MCI and prompt social interventions should be instituted to enhance their social functioning. Social isolation may indeed be a contributory risk factor for developing cognitive impairment. However, causal relationships and reverse causality should be evaluated in further longitudinal studies.

P90: The indirect role of supportive dyadic coping in the association between self- perceptions of aging and depression

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Objective: it has been shown that having negative-self perceptions of aging significantly predicts depressive symptomatology. Although the partner relationship may have an impact on the effects of perception of aging on distress, the number of studies assessing the effect of partner on negative self-perception of aging and mental health is limited. The stress of one partner may elicit dyadic coping (DC) responses in the other partner. The stress of one partner may elicit dyadic coping responses in the other partner. Depending on whether the responses are positive (supportive) or negative (hostile)a close relationship can go along with additional stress or resources and benefits. The present study analyzes the relationship between negative self-stereotypes and depressive symptomatology, considering the partner's dyadic coping as a moderator variable in this association.

Method: Participants were 365 individuals (59.3% women) 40 years or older (M= 60.86, SD=10.66) involved in a marital/partner relationship. Participants completed a questionnaire that included the variables: negative self-perception of aging, positive DC (e.g., "My partner shows empathy and understanding to me"), negative DC (e.g., "When I am stressed, my partner tends to withdraw"), and depressive symptomatology. Two moderation models were tested by linear regression: the first considered positive DC and the second negative DC as a moderator in the relationship between negative self-perception of aging and depressive symptoms.

Results: The effect of negative self-perceptions of aging on depressive symptoms was smaller among those who perceived higher levels of positive DC and lower levels of negative DC by their partners than among those perceiving lower positive DC and higher negative DC. The influence of supportive dyadic coping was higher when the levels of negative self-perception of aging were higher. Gender was a determinant factor in the moderation.

Conclusions: Positive DC mitigates the negative effects of negative self-perception of aging on wellbeing (by the mechanism of moderation), while negative DC amplifies this association and goes along with lower well-being in persons who report negative self-perceptions of aging. Training couples in supportive dyadic coping may be a resource to buffer the negative effect of negative self-perceptions of aging on well-being.

P94: Co-design of a theory-based implementation plan for a digital holistic assessment and decision support framework for people with dementia in care homes

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Background: Despite positive findings around the use of eHealth in dementia care, evidence for its efficacy is insufficient to ensure its adoption into routine care. Early involvement of end-users in the design of an implementation plan is a key strategy for promoting translation of findings into practice.

Objective: This study aimed to identify the requirements for use of an eHealth intervention to support assessment and decision making for use with people with dementia in care homes, and co-design strategies for its implementation.

Methods: A qualitative co-design method was applied through a series of workshops. Participants included family carers of people with dementia, and health and social care practitioners with direct experience of working with people with dementia. The workshops focused on identifying requirements for use and co-developing implementation strategies in response to factors identified to influence implementation. A deductive thematic analytic approach was taken, guided by the key concepts of the Normalisation Process Theory.

Results: Three workshops were conducted from July'21-November'21, attended by 39 participants. Three overarching phases of requirements were identified: 1) incentivising adoption of eHealth; 2) enabling operation of an eHealth intervention; 3) sustaining use of eHealth. Initial adoption requires promotion of the interventions benefits to engage stakeholders, and its alignment with national recommendations for good quality dementia care. Operationalising eHealth involves ensuring its compatibility with current care home processes and technology, provision of sufficient training and support from 'champions'. To sustain its use, ongoing monitoring of the implementation plan and provision of feedback to allow stakeholders to appraise its effects is required.

Conclusions: Implementing eHealth across a complex system of care homes is a multifaceted process. Using the key requirements identified in the workshops, we have developed a multi-strategy plan centered around three phases of implementation, to promote uptake of eHealth to support assessment and decision making for people with dementia in care homes. This is strengthened through collaborating with end-users to increases its value, credibility and real-world relevance. The theoretically informed strategies target mechanisms previously demonstrated to shape the implementation process and outcomes, ready for testing in care homes.