and explore the numerous approaches to operationalize social isolation in gerontological research. While associated with negative health outcomes and mortality, the interpretation of social isolation research is hampered by a lack of conceptual clarity and the use of numerous ad hoc measures of the concept. A systematic search was conducted for published empiric studies regarding social isolation health outcomes in older adult samples. The electronic databases: Medline, CINAHL, and PsycINFO were utilized. Reports including social isolation as an independent variable and health outcomes at the individual level were extracted. Of 2,614 studies initially identified, 14 met study criteria. Study outcomes recognized smoking cessation, sleep disruption, inadequate diet, risk for malnutrition, health-related quality of life, subjective well-being, cognitive function, psychological distress, depression, functional decline, stroke, myocardial infarction, and mortality as related to social isolation. Measurement strategies revealed numerous definitions of social isolation reporting to evaluate objective and subjective social isolation, loneliness, engagement, social disconnectedness, and perceived isolation. Measures utilized: eight ad hoc, three versions of the Lubben Social Network Scale, two versions of the Social Network Index, and one question from the Rand Social Battery. Continuing to develop knowledge regarding the predictive power of social isolation on health is important for the care of older adults. Distinguishing social isolation from related but distinctly different social concepts will facilitate the forward movement of the science. Reliably measuring social isolation will enable the comparison of results across studies.

THE INFLUENCE OF LONELINESS AND RURAL RESIDENCE ON DEPRESSION IN LATER LIFE

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Loneliness is associated with depression among older adults. Limited research has examined the role of rurality in relationship to loneliness and depression; the extant research has mixed findings. The socioemotional selectivity theory states that as people age the quality of relationships become more important than the quantity (English & Carstensen, 2016). Individuals in rural areas may have a low quantity of relationships but deeper social ties within the community; thus, they may be less likely to become depressed over time. The association between loneliness and depression may be amplified for people in non-rural areas because they are surrounded by other people but lack close relationships that are most important during the aging process. This study examines the effect of living in rural areas on loneliness on predicting baseline depression and loneliness, as well as changes in these outcomes over time. Data are from the 2006-2014 waves of Health Retirement Study. Regression models examine the relationship between depression loneliness and rural residence controlling for health conditions and demographic characteristics. Latent curve models examine the disparity in trajectories of loneliness and depressive symptoms by urban and rural residence. Older adults who feel lonely ($p<.001$) and in urban areas ($p<.0.05$) are more likely to be depressed. Furthermore, the effect of loneliness on depression is weakened by rural residence ($p<.05$). It is salient to understand the protective effect of rural residency on depression among older adults in the U.S. We discuss implications for policy.

SESSION 4155 (PAPER)

POLICIES TO INCREASE ACCESS AND ADDRESS DEPENDENCY

HETEROGENEITY IN MULTIDIMENSIONAL DEPENDENCY IN OLDER ADULTS IN MEXICO: A LATENT CLASS ANALYSIS APPROACH

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Background: The number of older adults expected to increase over the coming decades, the public health impact in this population may be substantial, and a greater understanding of the structure underlying risk factor presentation as a potential source of heterogeneity is critical. Objective: Identify and characterize profiles of dependency status in a population of dependent elderly individuals. Methods: The present study is based on the first wave of the Mexican Health Aging Study (MHAS). We included subjects aged 50 or older (n = 13,463 respondents interviewed in 2001). We performed Latent Class Analysis on four domains in older adults' indicators (physical, psychological, economic and social) to identify distinct classes of dependency profiles. We used LCA to group individuals into homogenous categories of dependency based on observed domains of multidimensional dependency. Multivariable logistic regression was conducted to examine the sociodemographic characteristics associated with each profile. Results: A 4-class solution based on cognitive performance at baseline was the best-fitting model. We characterized the four distinct classes of dependency profiles: active older adult, low, moderate and severe dependency that encompassed multiple dimensions of dependence. Using the "active older adult" class as the reference group, severe dependency, low dependency, and moderate dependency class were more likely to contain females, low education level and poor quality of life 3) the moderate dependency class was less likely to contain cigarette smoking and alcohol user. Conclusions: This study suggests that dependency do not follow a uniform adjustment pattern during the aging process, which reconciles inconsistent previous findings.

INNOVATIVE POLICIES AND TECHNOLOGIES TO INCREASE ACCESS TO HEARING AIDS FOR ADULTS

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