Vision impairment (VI) in older adults is associated with declines in well-being. However, the pathways through which poor vision leads to declines in well-being have not been well described. The purpose of this study was to determine whether activity limitations and social participation restrictions mediate the impact of self-reported VI on subjective well-being. This study used data from the National Health and Aging Trends Study (NHATS), a nationally-representative longitudinal study of Medicare beneficiaries 65 and older that includes detailed measures of the disablement process. We conceptualized a longitudinal mediation model linking self-reported VI and subjective well-being. Structural equation modeling was used to test the mediating effects of activity limitations and social participation restrictions while adjusting for covariates. The final sample included 5,431 respondents. At baseline, 8.0% of Medicare beneficiaries had self-reported VI. Subjective well-being scores were significantly lower among respondents with self-reported VI (15.7, 95% CI=15.2, 16.2) compared to those without VI (17.6, 95% CI=17.5, 17.7). Self-reported VI had a significant indirect effect on subjective well-being through limiting mobility (β=-.04, 95% CI=-.07, -.03) and household activities (β=-.05, 95% CI=-.08, -.03), but not self-care limitations (β=0.0, 95% CI=0.0, 0.0) or participation restrictions (β=0.0, 95% CI=-0.01, 0.00). Total indirect effects from all mediation paths accounted for 42% of the effect of VI on well-being. In conclusion, mobility and household activity limitations are significant mediators that explain a considerable portion of the impact of poor vision on well-being. Interventions to promote successful accommodation may result in greater well-being for visually impaired older adults.

SUBCLINICAL AGE-RELATED HEARING LOSS IS INVERSELY ASSOCIATED WITH DEPRESSIVE SYMPTOMS

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Age-related hearing loss (HL), defined by a pure-tone average (PTA) >25 decibels (dB) has been associated with depressive symptoms. We aimed to assess whether this association is present when hearing is better than the arbitrary, but widely-used, 25 dB threshold. The sampled population was the multicentered Hispanic Community Health Study (n=5,165). Cross-sectional data from 2008-2011 were available. Hearing was measured with pure tone audiometry. Clinically-significant depressive symptoms (CSDS) were defined by a score ≥10 on the 10-item Center for Epidemiologic Studies Depression Scale (CESD-10). Participants' mean age was 58.3 years (SD=6.2, range=50-76). Among those with classically-defined normal hearing (PTA ≤25 dB), a 10 dB increase in HL was associated with 1.26 times the odds (95% CI=1.11, 1.42) of CSDS, adjusting for age, gender, education, vascular disease, and hearing aid use (p25 dB; p<0.001). Results held even for a stricter HL cutpoint of 15 dB. Among subjects with strictly normal hearing (PTA ≤15 dB), a 10 dB increase in HL was associated with 1.47 (1.14, 1.90) times the odds of CSDS, adjusting for confounders (p<0.01). Results also held when defining CSDS by an alternative CESD-10 score ≥16. In conclusion, increasing hearing thresholds were independently associated with CSDS among adults with subclinical HL (PTA ≤25 dB). Studies investigating whether treating HL can prevent late life depression should consider a lower threshold for defining HL.

SESSION 2500 (SYMPOSIUM)

INTEREST GROUP SESSION—RURAL AGING: INNOVATIONS THAT SUPPORT RURAL OLDER ADULTS' HEALTH AND WELL-BEING: MODELS, NETWORKS, CASE STUDIES, REFLECTIONS

Chair: Roger O'Sullivan, *Institute of Public Health in Ireland, Belfast & Dublin, Ireland*
Co-Chair: Lyn Holley, *University of Nebraska, Omaha, United States*
Discussant: Marc A. Guest, *University of Kentucky, Lexington, Kentucky, United States*

Access of rural older people to health and wellness services is limited and becoming progressively more limited as trends toward increasing centralization of Government and private services continue. "Top-down" or urban centric models for rural service delivery often miss context essential to effectiveness and sustainability. In this symposium, each presenter in this multidisciplinary group of researchers presents innovative, community-based interventions that address these challenges using different methodologies and in respect to different needs Maiden (Psychology) compares the utilization of mental health services by rural older adults over time with their need for such services. Through the lens of social gerontology Holley examines networks of support that have intersected successfully to generate local solutions to unmet needs of rural-dwelling older adults. Crowther and Ford within a nursing and care context explore community-based models that draw upon the role of culture to integrate care for rural older adults. Katz, from an adult development perspective, reports on an educational game-intervention developed to reduce cognitive decline which is tailored specifically for older adults in rural areas. Wiese presents evidence from a pilot home-based approach that demonstrates a model for increasing rates of AD detection and treatment in a rural retired farm worker community in Florida. Our discussant, an emerging scholar in the field of rural gerontology, will reflect on the major themes that emerge from these multidisciplinary perspectives, especially the role of intersecting networks in community-based innovations and rural aging.

CASES OF OPTIMALLY LOCAL SOLUTIONS TO UNMET NEEDS OF RURAL-DWELLING OLDER ADULTS: ROLES OF NESTED NETWORKS

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Solutions developed top-down frequently make suboptimal use of resources. Programs (e.g., caregiver respite) are studied extensively; study focused on the roles of nested networks (family/locality/state/nation) that