disabilities in seven of Oregon's seventeen Area Agencies on Aging (AAAs). This poster describes the evaluation of the expansion using three data sources: administrative data about consumer characteristics compiled by the AAAs and State of Oregon from 2015-2017 (N=3,824 traditional consumers, N= 581 OPI-E consumers), qualitative interviews conducted with AAA directors and OPI-E case managers (N=23), and a survey of current OPI-E consumers (N=126). Compared to traditional OPI consumers, OPI-E consumers were somewhat more likely to be men and people of color. Interviews with AAA staff highlighted the need for outreach, lack of service provider capacity, unique characteristics of younger consumers, and issues related to data management and rural access. Staff reported valuing the program, noting how "even low levels of service go a long way." Qualitative and quantitative consumer responses showed consumers found OPI-E services invaluable. The majority stressed their appreciation for the program, with several describing it as "lifesaving." These three sources informed recommendations for expanding the OPI-E program statewide.

FEDERAL POLICY SUPPORTS AND GAPS IN ADDRESSING RACIAL-ETHNIC HEALTH DISPARITIES IN U.S. LONG-TERM CARE FACILITIES

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Older adults from racial and ethnic minority groups face health inequities in long-term care facilities such as nursing homes and assisted living facilities just as they do in the United States as a whole. In spite of federal policy to support minority health and ensure the well-being of long-term care facility residents, disparities persist in residents' quality of care and quality of life. This poster presents current federal policy in the United States to reduce racial and ethnic health disparities and to support long-term care facility residents' health and well-being. It includes legislation enacted by the Patient Protection and Affordable Care Act of 2010 (ACA), regulations of the U.S. Department of Health and Human Services (DHHS) for health care facilities receiving Medicare or Medicare funds, and policies of the Long-term Care Ombudsman Program. Recommendations to address threats to or gaps in these policies include monitoring congressional efforts to revise portions of the ACA, revising DHHS requirements for long-term care facilities staff training and oversight, and amending requirements for the Long-term Care Ombudsman Program to mandate collection, analysis, and reporting of resident complaint data by race and ethnicity.

SERVICE ENVIRONMENTS AND PSYCHOLOGICAL WELL-BEING AMONG RESIDENTIAL CARE FACILITY AND NURSING HOME RESIDENTS

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One's competence, or ability to cope, becomes lower as people age due to multiple factors, such as decreased physical and cognitive functioning, social isolation, and reduced income. Considering this change, providing appropriate services may help older adults to maintain their independence and improve their psychological well-being and quality of life. Therefore, this study aimed to investigate services that are positively associated with psychological well-being (i.e., mood, psychological health, self-efficacy) of older adults. For the analysis, observations were derived from the National Health and Aging Trends Study (NHATS), which includes a nationally representative sample of Medicare beneficiaries ages 65 and older. Service environments were assessed by (1) reflect availability and usage of 13 services (i.e., service unavailable, service available/ not being used, service available/ being used by residents) and (2) number of services available within three categories (i.e., help with ADL/IADL, transportation services, social and health-related services) Both having social events and activities available and participating in it were positively associated with older residents' mood, while using housekeeping services and walking areas (e.g., outdoor walking path) were associated with better psychological health and self-efficacy. When models were estimated with service categories, having more social and/or health-related services available were associated with better psychological health and self-efficacy. Findings of this study suggests that social events and activities, housekeeping services, and areas to walk for pleasure or exercise would improve older residents' psychological well-being. For Not only providing those services, residential facilities should encourage older residents to participation in or use the services.

SESSION 915 (POSTER)

PERSONALITY, PSYCHOSOCIAL, AND EMOTIONAL ELEMENTS

THE DOCTOR-PATIENT RELATIONSHIP, PERSONALITY, MOOD, AND FUNCTIONING IN OLDER ADULTS

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Personality pathology has been tied to mental and physical health in older adulthood. Less is known regarding the combined impact of personality and the doctor-patient relationship on mental health outcomes. This study examined relationships between personality, mood, and trust in physicians. Participants (N=170) were a sample of primary care older adults ages 60-99 (M = 70.73, SD = 7.054) who completed self-report measures of personality traits (NEO-FFI), processes (IIP-PD-25), depression (GDS-30; PHQ-9), social adjustment (SAS-SR) and trust in one's physician (GTIP). Medical burden data (CIRS) were retrieved from medical records. After adjusting for relevant covariates such as age, perceived health, cumulative illness burden, and income security there were several significant predictive relationships. In combined models more neuroticism (NEO-N, ß = .082, $p < .000$) and lower trust (GTIP, ß = -.025, p = .014) but not agreeableness (NEO-A, ß = -.006) or interpersonal problems (IIP-25, ß = .254) predicted depression. In combined models, higher neuroticism (NEO-N, ß = .018, $p < .000$) and interpersonal problems (IIP-25, ß = .186, p = .002) but not agreeableness (NEO-A, ß = -.003) or trust (GTIP, ß = -.002) predicted social adjustment. The results are consistent with previous findings that neuroticism predicts both depression and social adjustment in older adults. In addition, lower