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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As the proportion of older adults in the world's total population continues to grow, the deleterious downstream health economic outcomes of age-related hearing loss are steadily becoming more prevalent. While recent research has shown that age-related hearing loss is the single greatest modifiable risk factor for dementia, the rate of hearing aid use remains low in many countries across the globe. Reasons for poor uptake are multifactorial and likely involve a combination of factors, ranging from increasing costs of hearing aid technology to lack of widespread insurance coverage. This paper aims to first identify the current state of hearing aid access across the world using eight representative countries as examples. We then provide recommendations on how to facilitate greater access to hearing aids for consumers by addressing areas in regulation, technology, reimbursement, and workforce.

STRENGTH IN AGE-FRIENDLY HEALTH SYSTEMS: AN INNOVATIVE INTEGRATED INTERPROFESSIONAL MODEL

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This paper presents an innovative conceptual approach to health care policy for older adults: the Age-Friendly Health Systems Integrated Interprofessional Model. In 2017, the John A. Hartford Foundation and Institute for Healthcare Improvement, in partnership with the American Hospital Association and Catholic Health Association of the United States, advanced the concept of an Age-Friendly Health System. This initiative is designed to respond to the needs of a burgeoning U.S. older adult population, expected to double from 2012 to 2050, largely due to the aging of Baby Boomers and increased life expectancy. These Baby Boomers will demand a well-coordinated, communicative health system responsive to their values and preferences. In an Age-Friendly Health System, all older adults receive the best possible care, without care-related harms, and with satisfaction of care received. Essential elements include what matters, mentation, mobility, and medications, with a focus on patient-directed, family-engaged care. While a solid framework for improving healthcare for older adults, this model is further strengthened by incorporating the essential elements of person-, family-, and community-centered approaches to care; interprofessional team-based competencies, and Quadruple Aim outcomes. This enhanced model, referred to as the Age-Friendly Health System Integrated Interprofessional Model, combines elements essential to quality healthcare within the framework of an Age-Friendly Health System. This paper will present the original Age-Friendly Health System framework, the proposed Age-Friendly Health System Integrated Interprofessional Model, then compare and contrast each model's essential principles. Implications for adoption of this enhanced model for policy, education, and practice will be explored.

THE IMPACT OF MANDATED COGNITIVE ASSESSMENTS ON ALZHEIMER'S DISEASE AND RELATED DEMENTIA DIAGNOSIS RATES

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Although no cure for Alzheimer's disease exists, early diagnosis allows clinicians to detect reversible causes of memory loss, inform pharmacologic treatment options that may delay cognitive decline, and inform patients about clinical trial opportunities. It allows patients to communicate medical, legal, financial, living, and end-of-life desires. Barriers to diagnosis include low public awareness of early symptoms, stigma and misconceptions about the disease that delay seeking medical assistance. Provider-related barriers include low recognition of cognitive impairment and/or insufficient training in dementia diagnosis, and reimbursement issues. The new annual wellness visit (AWV) benefit available to Medicare Part B beneficiaries may reduce some of these barriers. The Patient Protection and Affordable Care Act of 2010 mandated an AWV that, along with routine preventive services, included for the first time, a cognitive screen at each visit. In this study, we analyze the effect of the introduction of the AWV benefit on Alzheimer's disease and related dementias (ADRD) diagnoses rates, average age at diagnosis and geographic dispersion of diagnoses. We use the 100% sample of Medicare claims and regression discontinuity to estimate the impact of the legislation enactment. Preliminary analyses show immediate and increasing take-up in AWV visits after the policy went into effect. The total number of preventative exams claims went from about 2,500 to 27,000 immediately after the policy and continued to grow in subsequent months. We also observe an increase in ADRD incidence in the months immediately following ACA, from about 14,000 claims in December 2010 to about 16,000 in January 2011.

SESSION 4160 (PAPER)

SUCCESSFUL AGING

A SELF-RELIANT UMBRELLA: DEFINING SUCCESSFUL AGING AMONG THE OLD-OLD (80+) IN SHANGHAI

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The Chinese old-old (80+) population has steadily increased in recent years; however, limited studies have examined how they age. The purpose of this study is to explore how the old-old in urban China define successful aging. Guided by grounded theory, community-dwelling old-old individuals participated in semi-structured, in-depth interviews (N= 97). Participants identified self-reliance as the goal of successful aging, which was supported by four proactive behaviors, including physical activity, financial security, community connectedness, and willing acceptance of reality. These four proactive behaviors were conceptualized to constitute the ribs of an umbrella model offering a canopy to protect the pole of self-reliant successful aging. This study offers new insight in understanding dynamic and nuanced ways that the old-old in urban China age successfully and their valiant efforts to maintain an ideal status.

COMMUNITY CAPACITY AND SOCIAL PARTICIPATION AMONG COMMUNITY-DWELLING MIDDLE-AGED AND OLDER CHINESE

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