complementary medicine is increasing among older adults with cancer and these modalities have the potential for both benefit and harm. Thus, it is important that health care professionals are knowledgeable about the evidence-supported benefits and risks of complementary and integrative health approaches in the care of older adults with cancer. Integrative cancer care provides a comprehensive approach to reducing symptom burden in patients suffering with cancer symptoms and side effects of cancer treatment. Symptoms such as pain, fatigue, nausea, sleep disturbance, mood disorder, perceived stress, and reduced quality of life are common in this population.This session will discuss an evidence-based integrative approach to cancer care which incorporates both pharmacologic and non-pharmacologic modalities to decrease symptom burden, enhance patient well-being, and improve quality of life. Non-pharmacologic modalities used in the integrative approach to care will be described and relevant evidence for risks, benefits and indications will be presented. Case studies will be discussed to demonstrate the integration of these techniques into conventional western medical treatment plans for older adults with cancer. Diversity and inclusion issues relevant to integrative medicine for underserved cancer patients will be addressed, as well as recommendations for future research to expand access of underserved populations to evidence-supported integrative cancer care. A resource list will be provided to participants.

FACTORS RELATED TO THE LONELINESS OF OLDER WOMEN WITH HYPERTENSION IN TEHRAN

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Older women have longevity and face with common chronic diseases such as hypertension longer than men. In addition the refusal to accept older women into the mainstream of society can affect the loneliness of older women particularly in developing countries such as Iran. This study was conducted to describe factors related to loneliness of older women with hypertension in Tehran. This descriptive, correlational study was conducted on a sample of 300 older women above age 60 in five regions of Tehran in 2020. A socio-demographic questionnaire and the Russell Loneliness Scale were used for data collection. Content validity and Cronbach's alpha were used for evaluating the validity and reliability of questionnaires. 61% of older women were widowed and 37.3% lived alone with a mean age of 72.16(± 8.5) year. The mean score for loneliness was 66.26 (±13.44) on a 20 to 80-point scale. The scores of loneliness were influenced significantly by not having an income source, no living companion, chronic diseases, hospitalization in last year, family history of hypertension, and duration of hypertension. The best predictors of loneliness were hospitalization in last year, duration of hypertension, family history of hypertension, and chronic diseases. The findings of this study showed that loneliness is very common in older women with hypertension and is related to a number of factors. Monitoring modifiable factors such as hospitalization in the last year and non-modifiable factors such as duration of hypertension will help us to prevent or reduce loneliness in older women with hypertension.

HEALTH TRAJECTORIES AFTER AGE 60: THE ROLE OF INDIVIDUAL BEHAVIOURS AND SOCIAL CONTEXTS

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This study aimed to detect different health trajectories after age 60, and to explore to what extent individual and social factors may contribute to healthier ageing. Twelve-year health trajectories were identified in subjects from the Swedish National Study on Aging and Care-Kungsholmen (N=3108), integrating five indicators related to diseases, physical and cognitive function, and disability by means of nominal response models. Growth mixture models were applied to explore health trajectories in terms of rate and pattern of change. Baseline information about health-related behaviours and social context was collected through standardized questionnaires. The strength of the associations was estimated using logistic regression, and their impact through population attributable fractions (PAF). Three trajectories were identified grouping 78%, 18%, and 4% of people with respectively increasing rates of health decline Compared to the best trajectory, subjects in the middle and worst trajectories became functionally dependent 12.0 (95%CI:11.4-12.6) and 12.1 (95%CI:11.5-12.7) years earlier, respectively. Insufficient physical activity (OR:3.38, 95%CI:2.58-4.42), financial strain (OR:2.76, 95%CI:1.77-4.30), <12 years education (OR:1.53, 95%CI:1.14-2.04), low social connections (OR:1.45, 95%CI:1.09-1.94), low social participation (OR:1.39, 95%CI:1.06-1.83) and a body mass index ≥25 (OR:1.34, 95%CI:1.03-1.75) were associated with belonging to the middle/worst trajectories. The highest PAFs were observed for insufficient physical activity (27.1%), low education (19.3%) and low social participation (15.9%); a total PAF of 66.1% was obtained when considering all significant exposures together. Complementarily considering life-long factors belonging to the socioeconomic, psychosocial, and behavioural dimensions should be central to any strategy aimed at fostering health in older age.

HYPERTENSION DIAGNOSIS, TREATMENT, AND CONTROL AMONG OLDER CHINESE: TRENDS IN THE HYPERTENSION CARE CASCADE

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Hypertension is a major risk factor for cardiovascular disease, which is the leading cause of death in China. Older persons are at higher risk of elevated blood pressure and are more likely to have insufficient hypertension care, including delayed diagnosis and poor management. However, we know little about hypertension care among older Chinese at a population level. We use a nationally representative sample of older adults from the China Health

and Retirement Longitudinal Study (CHARLS) in 2011 and 2015 (n = 9,083), to clarify the hypertension care cascade for the older population in China by specifying the level of diagnosis, treatment, and control of hypertension. We then examine the characteristics of those (1) who received appropriate hypertension care and (2) whose care improved over time. Diagnosis and care improved between 2011 and 2015. Among those with hypertension, 55% and 67% were diagnosed in 2011 and 2015 respectively; 46% and 60% were treated with modern medication; and 20% and 29% were effectively controlled. Those who had higher income (OR=1.52; P<0.01) or obese (OR=2.43; P<0.001) were relatively more likely to be diagnosed, while those living in the western region (OR=0.65; P<0.01) or living in urban areas with a rural hukou (OR=0.54; P<0.01) were less likely. Persons age 75+ (OR=0.55; P<0.05) were less likely to have their blood pressure controlled, while those who had higher income (OR=1.50; P<0.05) were more likely. The improvement from 2011 to 2015 in hypertension care was concentrated among those that are obese or living in the West.

IS CANCER HISTORY RELATED TO NEUROLOGIC SPECIALTY CARE IN PATIENTS WITH DEMENTIA?

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Background: The incidence and prevalence of aging-related diseases such as dementia and cancer are increasing, as are cancer survival rates. Cancer and its treatments have been associated with cognitive effects for those who later develop dementia. Guidelines have suggested that cancer patients return to follow-up in primary care following remission and be referred to specialists for cognitive complications, but it is unclear how well these guidelines are followed. Methods: Electronic health record data at the University of Alabama at Birmingham were extracted from July 2003 May 2020. Rates of specialty care utilization on or after dementia diagnosis were compared by cancer history status in adults 50 years old or older at dementia diagnosis. Predictors of specialty care utilization were examined using logistic regression. Results: Rate of specialty care utilization was lower for those with cancer history compared to those without on the date of dementia diagnosis (11.3% vs. 17.1%) and after diagnosis (13.5% vs. 19.2%). Older age at dementia diagnosis, non-Hispanic Black race, anticholinergic burden, socioeconomic status, and vascular risk factors were associated with lower odds of specialty care utilization. Dementia medication use was associated with higher odds of specialty care utilization on and after dementia diagnosis. Conclusions: Cancer survivors with a dementia diagnosis are less likely to utilize specialty care than those with no history of cancer. Several factors predicted specialty care utilization. Additional studies should assess potential barriers in referring cancer survivors to specialty care for cognitive impairment.

MARKERS OF GLUCOSE METABOLISM AND MUSCLE STRENGTH DECLINE AMONG THE OFFSPRING OF LONG-LIVED INDIVIDUALS

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Diabetes has been linked to accelerated muscle strength decline with aging. However, the association between glucose metabolism and muscle strength decline among individuals without diabetes is less clear. We tested whether fasting plasma markers of glucose and insulin metabolism (glucose, insulin, hemoglobin A1c, and soluble receptor for advanced glycation end products (sRAGE)) are associated with grip strength decline among 1415 non-diabetic offspring of exceptionally long-lived individuals who have a low diabetes risk (age range 36-88; mean age ± SD = 60 ± 8 years; mean BMI ± SD = 27 ± 4.7 kg/m2; 57% women). Grip strength was assessed using a hand-held dynamometer at two clinic visits over an average of 7.9 years. Multiple linear mixed models were adjusted for age, sex, field center, lifestyle, comorbidities, body weight, height, weight change, and family relatedness. Each standard deviation higher fasting insulin (7.3 mIU/L) was related to greater grip strength decline (-0.38 ± 0.16 kg; p=0.016), while each standard deviation higher fasting sRAGE (430 pg/mL) was related to slower grip strength decline (0.36 ± 0.18 kg; p=0.04). Our findings suggest that even among non-diabetic individuals from families with a clustering of "healthier" metabolic profiles - insulin metabolism and advanced glycation end products may be important biomarkers of muscle strength decline with aging. Potential mechanisms, including genetic and metabolic mediators underlying the observed associations, warrant further investigation.

OLDER ADULT MAINTAINING AND IMPROVING HEALTH SELF-MANAGEMENT THROUGH PEER SUPPORTED SMART GOAL SETTING

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Non-medical interventions to address risk factors (such as reducing smoking, increasing physical activity, and tackling limited social interaction) are needed to help tackle escalating social and financial health costs. Peer supported interventions have been used successfully to support persons' health self-management; however, there is limited evidence for group interventions facilitated by older adults. A proof-of-concept study by the first author demonstrated the potential of older adults meeting in groups to each create and follow through with a single SMART goal for any area of health over one-month. This study extends SMART goal setting to enhancing health management over six months. Older adult participants from across Ontario will attend virtual SMART goal setting group sessions followed by six monthly support group meetings where they are free to choose any goal, whether a mitigation or a new behavior. Each month