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