Health, New York, New York, United States, 2. UCLA School of Nursing, Los Angeles, California, United States, 3. VA Greater Los Angeles Healthcare System, UCLA, North Hills, California, United States

Promoting healthy aging does not end when people enter skilled nursing facilities (SNF) where the demands for clinical and psychosocial care are likely to be greatest. Many chronic conditions present opportunities for better SNF care and thus, healthier aging. Such conditions cannot wait for the often-long path to discovery that is typical of most traditional randomized controlled clinical trials. Conversely, pragmatic clinical trials are real-world investigations that offer the possibility of immediate benefit while answering important research questions. Depression and disrupted sleep are two examples of treatable conditions with opportunities for immediate benefit through pragmatic trials and applied best practices. How best to support best-practice integration has received increasing attention but identifying the most effective strategies continues to evolve. We report two different SNF-mentorship models utilizing Minimum Data Set (MDS) data for depression and environmental (noise-level) data for disrupted sleep, which have supported better SNF practices and presumably, healthier aging.

SESSION 1300 (POSTER)

AGEISM | DISPARITIES | DIVERSITY

RACIAL-ETHNIC DISPARITY IN DENTAL CARE IN NURSING HOMES

Zhiqiu Ye,[1] and Bei Wu[2], *1. University of Rochester Medical Center, Rochester, New York, United States, 2. New York University, New York, New York, United States*

Minority older adults are at higher risks of poor oral health. Little is known about the extent of and the contributing factors to racial/ethnic disparity in dental care quality in the long-term care settings. Previous studies suggest that organizational and system-level factors are key determinants of oral health among minority older adults. We examined the racial/ethnic disparity in dental care delivery in nursing homes (NHs) by facility and market characteristics. We analyzed the 2000-2016 national Inspection Survey data for all certified-NHs (n=248,975 facility-years). Two designated deficiency citations were used to measure dental care performance. Generalized estimating equations were used to compare the rates of deficiency citations among NHs in different quartiles of the share of minority residents, adjusting for facility characteristics, market characteristics, year and state fixed effects. Overall, compared to NHs in the lowest quartile of the share of minority residents (average % minority residents =0.24%), NHs in the highest quartile of the share of minority residents (average % minority residents = 46.5%) and those in the second highest share (average % minority residents=13.9%) had 46.8% and 31.2% higher odds of receiving dental care citations($p<0.001$ for both), respectively. The increased citation rates persisted over time ($p=0.40$) and were greater among for-profit NHs ($p=0.02$). Our study suggests that minority older adults in NHs are disproportionately affected by poorer dental care performance. There is a great need to improve quality of dental care in NHs, particularly for those that are for-profit and those that disproportionately serve minority residents.

SCALES FOR MEASURING AGEISM AS EXPERIENCED BY OLDER ADULTS: LITERATURE REVIEW AND METHODOLOGICAL CRITIQUE

Hyun Kang[1], *1. University of Kansas, Lawrence, Kansas, United States*

A growing body of research shows that ageism negatively affects older adults' psychological well-being and even physical functioning. However, the tools to measure ageism as experienced by older adults are not well developed. This study reviewed the literature on ageism scale with an emphasis on the methodological issues. Most standardized ageism scales have focused on younger people's attitudes and beliefs toward older adults. We found only one standardized scale that examined how older adults felt and thought about their experiences being treated as a stereotype. However, the scale is incomplete because it does not fully measure ageism and it has received far less rigorous analysis. Many studies have adopted and revised ageism scales that were developed specifically to measure younger people's attitudes toward older adults, meaning that the scales' validity has been problematic when administered to older adults. Furthermore, many studies that discussed older adults' experience of ageism used uni-dimensional or simple measures. Although significant efforts have been made to outline ageism's various dimensions and constructs, these efforts have not led to a common consensus on ageism and its characteristics. Lack of consensus, in turn, makes it harder to develop a standardized scale. Finally, existing scales are more suitable for Western societies. Socio-cultural uniqueness has not been considered when developing scales, nor has the scales' cross-cultural reliability and validity been tested. Our findings suggest that a new scale that applies only to measuring ageism as perceived by older adults and corresponds to the significant dimensions of ageism must be developed.

LONGITUDINAL MENTAL HEALTH CONSEQUENCES OF PHYSICAL DISABILITIES: THE MEDIATING ROLE OF PERCEIVED DISCRIMINATION

Eun Ha Namkung,[1] and Deborah Carr[2], *1. Brandeis University, Waltham, Massachusetts, United States, 2. Boston University, Boston, Massachusetts, United States*

Individuals with disabilities have been historically mistreated by discrimination. The detrimental mental health effects of self-reported interpersonal discrimination are well established. However, little empirical attention has been given to the role of perceived discrimination in the adverse mental health outcomes of adults with physical disabilities. This study aims to examine whether daily interpersonal discrimination (i.e., microaggression) mediates the prospective association between having a functional impairment and subsequent changes in the individuals' mental health outcomes over their midlife and old age. To address this question, this study used data from two waves of a population-based national study, the National Survey of Midlife Development in the United States, covering a 7- to 9-year period (n= 2,503; Mage at baseline = 57, SDage = 11). Physical disability or functional impairment was assessed with items adapted from the SF-36, capturing difficulty with nine activities of

daily living. Having functional impairment at the baseline assessment was associated with increases in depressive symptoms and negative affect over the study period. Daily interpersonal discrimination partially mediated this longitudinal association, explaining 7.4% (for depressive symptoms) to 8.1% (for negative affect) of the total effects. Exposure to discrimination and its mental health consequences were also more pronounced at younger ages. Disability-related perceived discrimination is an under-recognized mechanism that is likely to contribute to mental health inequities in later life. Professionals in health and disability policy, research, and practice need to concentrate efforts on developing policy and programs that reduce discrimination experienced by US adults with disabilities.

CORRELATES OF BREAST CANCER SCREENING BEHAVIORS AMONG INDIGENOUS WOMEN

Soonhee Roh,[1] Yeon-Shim Lee,[2] Kyoung Hag Lee,[3] and Jung Sim Jun[4], *1. University of South Dakota, Sioux Falls, South Dakota, United States, 2. San Francisco State University, San Francisco, California, United States, 3. Wichita State University, Wichita, Kansas, United States, 4. Kansas State University, MANHATTAN, Kansas, United States*

Cervical cancer remains a significant cause of morbidity and mortality among women globally; yet cancer burden is unevenly distributed among racial/ethnic groups. With 12,820 new cases in 2017 in the U.S., cervical cancer is the top cause of death among Indigenous women. Indeed, cervical cancer mortality rates among AI women in South Dakota are five times the national average and 79% higher compared to Whites in that region. This study examined predictive models of utilization of mammograms among Indigenous women adapting Andersen's behavioral model. Using a sample of 285 Indigenous women residing in South Dakota, nested logistic regression analyses were conducted to assess predisposing (age and marital status), need (personal and family cancer history), and enabling factors (education, monthly household income, mammogram screening awareness, breast cancer knowledge, self-rated health, and cultural practice to breast cancer screening). Results indicated that only 55.5% of participants reported having had a breast cancer screening within the past 2 years, whereas 21.0% never had a mammogram test. After controlling for predisposing and need factors, higher education, greater awareness of mammogram, and higher utilization of traditional Native American approaches were significant predictors of mammogram uptake. The results provide important implications for intervention strategies aimed at improving breast cancer screening and service use among Indigenous women. Educating health professionals and Indigenous community members about the importance of breast cancer screening is highly needed. It is critical to assess a woman's level of traditional beliefs and practices and its possible influence on screening participation and future screening intention.

WE CAN'T AVOID IT. IT'S THERE! AGEISM EXPERIENCED BY DIVERSE CULTURAL GROUPS IN OTTAWA, CANADA

Caroline D. Bergeron,[1] and Martine Lagacé[2], *1. Bexar County Community Health Collaborative, San Antonio, Texas, United States, 2. University of Ottawa, Ottawa, Ontario, Canada*

Introduction: Discrimination based on age is pervasive across Canada. Little is known about the experiences of ageism among diverse cultural groups. The purpose of this pilot study was to explore the perceptions of ageism among culturally diverse older adults in Ottawa, Canada. Methods: Three focus groups were conducted with Chinese, Arab, and Indian older adults in Ottawa in June 2016. An 8-item protocol was developed to guide the discussions. Qualitative data were analyzed using open, axial, and selective coding. Results: Twenty-five culturally diverse older adults (9 Chinese, 6 Arab, and 10 Indian) participated in the focus groups. All described personal positive and negative examples of discrimination based on their age without being familiar with the term "ageism". Several described their experiences with the intersection of age, race, and gender, although these interpretations varied by cultural group. Ageism in the media was also easily recognized. Participants recommended using specific content, communication channels, and organizations to counteract ageism. Discussion: This pilot study helped to illustrate that ageism is a societal problem that requires a societal solution. As Canada's population becomes older and more diverse, important efforts are needed to raise awareness of ageism.

OLDER ADULT HEALTH IN THE CITY OF CHICAGO

Brittney S. Lange Maia,[1] Emily Laflamme,[2] Fernando DeMaio,[3] and Raj C. Shah[4], *1. Rush University Medical Center, Chicago, Illinois, United States, 2. Chicago Department of Public Health, Chicago, Illinois, United States, 3. DePaul University, Chicago, Illinois, United States, 4. Rush University, Chicago, Illinois, United States*

In 2012, Chicago was designated as an Age Friendly City. However, city-wide data on the health and health disparities experienced by older adults have been scarce. In order to address this knowledge gap, the Chicago Department of Public Health (CDPH) partnered with the Center for Community Health Equity at Rush and DePaul Universities to create a report describing health status among adults age 65+. Data were from the Healthy Chicago Survey—a population-based health survey conducted by CDPH, the American Community Survey, Hospital Discharge Data, and State Vital Records. The report highlights considerable racial/ethnic diversity in Chicago, as 38% of older adults are white, 37% black, 18% Latinx, and 7% are Asian. Encouraging results exist regarding healthcare access; 96% have a personal health care provider and 89% report being able to get care needed through their health plan. Several areas of improvement are needed regarding root causes of health. More older adults live below the federal poverty level (15.9%) compared to the overall U.S (9.3%), and 45.8% would be unable to pay for an unexpected $400 expense. Disparities were evident as life expectancy at age 65 is 2.5 years longer for Latinx and white older adults (age 85) compared to African Americans (age 82.4). African American and Latinx older adults had higher rates of preventable hospitalizations per 10,000 (801.1 and 678.9, respectively) compared to white (492.4) and Asian (374.1) older adults. Findings from this report will spur