Vision impairment (VI) in older adults is associated with declines in well-being. However, the pathways through which poor vision leads to declines in well-being have not been well described. The purpose of this study was to determine whether activity limitations and social participation restrictions mediate the impact of self-reported VI on subjective well-being. This study used data from the National Health and Aging Trends Study (NHATS), a nationally-representative longitudinal study of Medicare beneficiaries 65 and older that includes detailed measures of the disablement process. We conceptualized a longitudinal mediation model linking self-reported VI and subjective well-being. Structural equation modeling was used to test the mediating effects of activity limitations and social participation restrictions while adjusting for covariates. The final sample included 5,431 respondents. At baseline, 8.0% of Medicare beneficiaries had self-reported VI. Subjective well-being scores were significantly lower among respondents with self-reported VI (15.7, 95% CI=15.2, 16.2) compared to those without VI (17.6, 95% CI=17.5, 17.7). Self-reported VI had a significant indirect effect on subjective well-being through limiting mobility (β=-.04, 95% CI=-.07, -.03) and household activities (β=-.05, 95% CI=-.08, -.03), but not self-care limitations (β=0.0, 95% CI=0.0, 0.0) or participation restrictions (β=0.0, 95% CI=-0.01, 0.00). Total indirect effects from all mediation paths accounted for 42% of the effect of VI on well-being. In conclusion, mobility and household activity limitations are significant mediators that explain a considerable portion of the impact of poor vision on well-being. Interventions to promote successful accommodation may result in greater well-being for visually impaired older adults.

SUBCLINICAL AGE-RELATED HEARING LOSS IS INVERSELY ASSOCIATED WITH DEPRESSIVE SYMPTOMS

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Age-related hearing loss (HL), defined by a pure-tone average (PTA) >25 decibels (dB) has been associated with depressive symptoms. We aimed to assess whether this association is present when hearing is better than the arbitrary, but widely-used, 25 dB threshold. The sampled population was the multicentered Hispanic Community Health Study (n=5,165). Cross-sectional data from 2008-2011 were available. Hearing was measured with pure tone audiometry. Clinically-significant depressive symptoms (CSDS) were defined by a score ≥10 on the 10-item Center for Epidemiologic Studies Depression Scale (CESD-10). Participants' mean age was 58.3 years (SD=6.2, range=50-76). Among those with classically-defined normal hearing (PTA ≤25 dB), a 10 dB increase in HL was associated with 1.26 times the odds (95% CI=1.11, 1.42) of CSDS, adjusting for age, gender, education, vascular disease, and hearing aid use (p25 dB; p<0.001). Results held even for a stricter HL cutpoint of 15 dB. Among subjects with strictly normal hearing (PTA ≤15 dB), a 10 dB increase in HL was associated with 1.47 (1.14, 1.90) times the odds of CSDS, adjusting for confounders (p<0.01). Results also held when defining CSDS by an alternative CESD-10 score ≥16. In conclusion, increasing hearing thresholds were independently associated with CSDS among adults with subclinical HL (PTA ≤25 dB). Studies investigating whether treating HL can prevent late life depression should consider a lower threshold for defining HL.

SESSION 2500 (SYMPOSIUM)

INTEREST GROUP SESSION—RURAL AGING: INNOVATIONS THAT SUPPORT RURAL OLDER ADULTS' HEALTH AND WELL-BEING: MODELS, NETWORKS, CASE STUDIES, REFLECTIONS

Chair: Roger O'Sullivan, *Institute of Public Health in Ireland, Belfast & Dublin, Ireland*
Co-Chair: Lyn Holley, *University of Nebraska, Omaha, United States*
Discussant: Marc A. Guest, *University of Kentucky, Lexington, Kentucky, United States*

Access of rural older people to health and wellness services is limited and becoming progressively more limited as trends toward increasing centralization of Government and private services continue. "Top-down" or urban centric models for rural service delivery often miss context essential to effectiveness and sustainability. In this symposium, each presenter in this multidisciplinary group of researchers presents innovative, community-based interventions that address these challenges using different methodologies and in respect to different needs Maiden (Psychology) compares the utilization of mental health services by rural older adults over time with their need for such services. Through the lens of social gerontology Holley examines networks of support that have intersected successfully to generate local solutions to unmet needs of rural-dwelling older adults. Crowther and Ford within a nursing and care context explore community-based models that draw upon the role of culture to integrate care for rural older adults. Katz, from an adult development perspective, reports on an educational game-intervention developed to reduce cognitive decline which is tailored specifically for older adults in rural areas. Wiese presents evidence from a pilot home-based approach that demonstrates a model for increasing rates of AD detection and treatment in a rural retired farm worker community in Florida. Our discussant, an emerging scholar in the field of rural gerontology, will reflect on the major themes that emerge from these multidisciplinary perspectives, especially the role of intersecting networks in community-based innovations and rural aging.

CASES OF OPTIMALLY LOCAL SOLUTIONS TO UNMET NEEDS OF RURAL-DWELLING OLDER ADULTS: ROLES OF NESTED NETWORKS

Lyn Holley,[1] Kara l. Kohel,[2] Holly Hatton-Bowers,[2] and Susan Harris-Broomfield[2], *1. University of Nebraska, Omaha, United States, 2. University of Nebraska–Lincoln, Lincoln, Nebraska, United States*

Solutions developed top-down frequently make suboptimal use of resources. Programs (e.g., caregiver respite) are studied extensively; study focused on the roles of nested networks (family/locality/state/nation) that

intersect in care is lacking. To identify and assess potential for improving solutions, this study examines cases acknowledged to provide optimal support. It identifies and describes network roles and intersections critical to success, with particular attention to timing and intentionality of family and community interfaces. Findings may suggest improved design and operation of programs through targeted empowerment of networks Cases were identified in cooperation with the Nebraska Extension service, and analyzed by a multidisciplinary team that included Family Science and Gerontology. Rural-dwelling older adults who benefited from the solution, expert practitioners, officials and local champions were interviewed. Analysis included private and public actors, and explains outcomes within a cultural (e.g., individualist, independent) and opportunity (e.g. information, financial and human resources) framework (Gelfand, 2003).

IDENTIFYING BARRIERS TO MENTAL HEALTH SERVICES IN A RURAL COMMUNITY

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Unmet mental health care needs of older people living in rural areas have been identified as a fundamental problem. This project engaged a rural consortium of service agencies to support recruitment through advertising, word of mouth, social media. So far, 100 rural participants aged 50 and older have completed our survey which includes the revised Barriers to Mental Health Services Scale, (BMHSS-R) which measures intrinsic barriers attributed to internal characteristics and beliefs, e.g. stigma, and extrinsic barriers, e.g. insurance costs, and lack of transportation. Preliminary results revealed increased services utilization compared to past research. However, several serious barriers remained, e.g. as lack of insurance/costs, distance/location, stigma, and lack of knowledge. The BMHSS-R results e demonstrate how the two types of barriers are related and interact within individuals. Implications are that internal barriers (e.g., stigma) and external ones (location, costs) can be reduced or eliminated through integrated medical/behavioral services.

USING COMMUNITY-BASED MODELS TO PROVIDE INTEGRATED CARE FOR RURAL OLDER ADULTS

Martha R. Crowther,[1] and Cassandra D. Ford[2], *1. The University of Alabama, Tuscaloosa, Alabama, United States, 2. The University of Alabama, Capstone College of Nursing, Tuscaloosa, Alabama, United States*

Rural elders are one of the most at-risk populations for experiencing physical and mental health problems. In many rural communities, there are no psychosocial services available to meet the needs of the rural elderly. To provide rural older adults with integrated healthcare, we build upon our existing community-based infrastructure that has fostered community capacity for active engagement in clinical activities and has served as a catalyst to increase participation of rural older adults in clinical services. Our rural community model draws upon the role of culture in promoting health among rural older adults to provide rural service delivery. This model is built upon our network of partnerships with surrounding communities, including potential research participants, community-based organizations, community leaders, and community health-care systems and providers. By engaging the community we can create a sustainable system that will encourage rural older adults to utilize the health care system at a higher rate.

A COMMUNITY-BASED INTERVENTION TO IMPROVE COGNITIVE FUNCTION IN RURAL APPALACHIAN OLDER ADULTS

Benjamin Katz[1], *1. Virginia Tech, Blacksburg, Virginia, United States*

Research suggests that social isolation in Appalachian older adults may be associated with reduced cognitive function. Despite this, few interventions for these individuals incorporate both social and cognitive components in a community-based setting. The "Memory Masterclass" program was developed to address this care challenge, and implemented through an Adult Day Services Center. With 29 community-dwelling older adult participants from western Virginia, the six-week pilot program focused on strategies and practices associated with improving long-term memory or executive function. In addition to the lifestyle-focused curricula, the course included group activities focused on connecting participants to community networks of resources that might enable them to successfully implement lifestyle changes. Findings support the feasibility of implementation with a wider group of rural Appalachian older adults and suggest that individual differences in self-reported memory may be closely tied to improvements following the program.

LEARNING FROM IN-DEPTH COGNITIVE ASSESSMENTS CONDUCTED IN RURAL INDEPENDENT LIVING FACILITIES

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Despite benefits to earlier Alzheimer's disease interventions, efforts to increase dementia detection and treatment in high-risk rural areas are lacking. Barriers include lack of resources, including limited time for providers to conduct in-depth cognitive assessments. A pilot program tested the effectiveness of a home-based approach for increasing rates of AD detection and treatment in a rural retired farmworker community. Depression and cognitive screenings of 139 residents conducted by community health workers were followed up with in-depth geriatric-focused assessments, including the Moca-B, by experienced, culturally diverse adult gerontological nurse practitioners (AGNPs). Their findings were forwarded to primary providers. This approach was evaluated for effectiveness using correlations, regressions, and Chi-square analyses of variables on rates of ADRD screening, referrals, and ADRD diagnosis.