Late-life depression is a burden on society because it is costly and have a significant adverse effect on the quality of life. The aim of this study is to evaluate the cost-effectiveness of the collaborative stepped care intervention for depression among community-dwelling older adults compared to care as usual from a societal perspective. The intervention was piloted from 2016-2019 in Hong Kong. The study used a two-armed quasi-experimental design. Eventually, 412 older people were included (314 collaborative stepped care, 98 care as usual). Baseline measures and 12-month follow-up measures were assessed using questionnaires. We applied the 5-level EQ-5D version (EQ-5D-5L) and the Client Service Receipt Inventory (CSRI) respectively measuring quality-adjusted life-year (QALY) and health care utilization. The average annual direct medical cost in the intervention group was USD 6,589 (95% C.I., 4,979 to 8,199) compared to US$ 6,167 (95% C.I., 3,702 to 8,631) in the care as usual group. The average QALYs gained was 0.036 higher in the collaborative stepped care group, leading to an incremental cost-effectiveness ratio (ICER) of US$ 11,722 per QALY, lower than the cost-effectiveness threshold suggested by The National Institute for Health and Clinical Excellence. The study showed that collaborative stepped care was a cost-effective intervention for late-life depression over service as usual.

THE RELATIONSHIP OF FRAILTY, FEAR OF FALLING, AND DEPRESSION WITH HRQOL IN HIGH-RISK OLDER ADULTS
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One in four older adults fall every year. Falls result in negative outcomes including decreased health-related quality of life (HRQoL). Frailty, fear of falling, depression, and HRQoL are not routinely screened in high-risk community-dwelling older adults. Continued study of modifiable fall risk factors is warranted due to varied reported prevalence rates, inconsistent definitions and the persistent high rate of falls resulting in poor HRQoL. The purpose of the study was to determine the relationship between frailty, fear of falling, and depression with physical and mental functioning and well-being measures of HRQoL in community-dwelling older adults 55 years of age and older. A cross-sectional correlational design and chart review were conducted. The sample consisted of 84 primarily African American (81%) nursing home eligible members of the Program for All-Inclusive Care for the Elderly (PACE) program. Data were analyzed with correlational statistics, multiple linear, and hierarchical regression models. Physical functioning and well-being measures were significantly decreased when compared to the general population. Increased frailty, fear of falling, and depression were associated with decreased physical and mental well-being. In the regression model, frailty and fear of falling were significant predictors of decreased physical functioning and well-being, and depression was a significant predictor of decreased mental functioning and well-being. This study provides clarification of the relationship between frailty, fear of falling, and depression with HRQoL in high-risk older adults. Screening for common modifiable risk factors can assist in the development of targeted interventions and treatments to improve HRQoL in high-risk older adults.

PREDICTORS OF HEALTH-RELATED QUALITY OF LIFE AND RECOVERY AMONG OLDER ADULTS WITH SERIOUS MENTAL ILLNESS
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Older adults with serious mental illness (i.e., schizophrenia spectrum disorders and affective psychoses) exhibit marked impairments across medical, cognitive, and psychiatric domains. The present study examined predictors of health-related quality-of-life and mental health recovery in this population. Participants (N=211) were ages 50 and older with a chart diagnosis of serious mental illness and a co-occurring medical condition, engaged in outpatient mental health services at a study site. Participants completed a battery of assessments including subtests from the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), the 24-Item Behavior and Symptom Identification Scale (BASIS-24), the 12-Item Short-Form Health Survey (SF-12), and the Maryland Assessment of Recovery Scale (MARS). Multiple linear regression analyses, with age, race, gender, and BMI as covariates, examined number of current medical conditions, RBANS, and BASIS as predictors of quality-of-life and recovery. Significant predictors of physical health-related quality-of-life (R-squared=.298, F(9,182)=8.57, p<.0001) were number of medical conditions (β=-1.70, p<.0001), BASIS-Depression/Functioning (β=-1.30, p=.03), BASIS-Depression/Functioning (β=-3.17, p<.0001), and BASIS-Psychosis (β=2.39, p<.0008). Significant predictors of mental health-related quality-of-life (R-squared=.575, F(9,182)=27.37, p<.0001) were RBANS (β=-0.03, p=.05), BASIS-Depression/Functioning (β=-6.49, p<.0001), BASIS-Relationships (β=-3.17, p<.0001), and BASIS-Psychosis (β=-1.30, p=.03). Significant predictors of MARS (R-squared=.434, F(9,183)=13.56, p<.0001) were BASIS-Depression/Functioning (β=-4.68, p=.002) and BASIS-Relationships (β=-9.44, p<.0001). To promote holistic recovery among older adults with serious mental illness, integrated interventions are required. For example, to improve physical health-related quality-of-life, one should target depression and psychotic symptoms as well as medical illness burden. To improve mental health-related quality-of-life, depression symptoms and interpersonal functioning may be key targets, as well as neurocognitive function.

BROODING MODERATES THE RELATIONSHIP BETWEEN CEREBROVASCULAR BURDEN AND VASCULAR DEPRESSION
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Objective: The vascular depression hypothesis posits that cerebrovascular burden confers risk for late-life depression. Though neuroanatomical correlates of vascular depression (prefrontal white matter hyperintensities) are well established,
little is known about cognitive correlates; the identification of which may suggest therapeutic targets. Aims of this study are to examine the hypothesis that the relationship between cerebrovascular burden and depressive symptoms is moderated by brooding, a type of rumination. Method: A sample of 52 community-dwelling, stroke-free, individuals over the age of 70, without history of severe mental illness or dementia completed the Ruminative Responses Scale, and provided self-report (cardiac disease, hypertension, diabetes, high cholesterol) CVB data. The Geriatric Depression Scale was used to assess depressive symptomatology. Results: Results of a bootstrapped model were that self-reported measures of CVB predicted depressive symptomatology. This relationship was significantly moderated by brooding. Among older adults, those who self-reported high CVB and medium to elevated levels of rumination experienced disproportionately more depressive symptomatology. Conclusions: These findings suggest that brooding rumination may be one correlate of the vascular depression syndrome. Future research should examine neuroanatomical correlates of rumination among older adults, and further explore brooding as a therapeutic target for those with late-life depression.

SMART HOME TECHNOLOGY FOR OLDER ADULTS WITH MOBILITY DISABILITIES: POTENTIAL AND CHALLENGES

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Recently, there has been a significant expansion in the number of smart and connected technologies for assisting individuals with a variety of tasks within the home. Examples include digital home assistants (e.g., Amazon Echo), smart lights, smart plugs, robotic vacuums, as well as a multitude of other devices. Such technologies hold the potential to support independence for older adults with long-term mobility disabilities, as they may experience challenges engaging in daily activities. The aim of the current study was to utilize a comprehensive approach with an interdisciplinary team to improve understanding of how to integrate smart technology into older adults’ homes. We focused on identifying functionality that would be useful to them, understanding their perceptions, and developing instructional support. We conducted interviews among older adults with, and without, long-term mobility disabilities to better understand their attitudes towards digital assistants, identify needs for instructional support, and test the usability of our instructional protocol. The overall goal of this research is to improve understanding of older adults’ perceptions of these technologies and identify usability challenges within the home. The instructional protocol offers support by reducing the identified barriers to initial adoption and continued use to promote aging-in-place and improving overall quality of life for older adults with long-term mobility disabilities.

BARRIERS TO ORAL HEALTH IN THE OLDER POPULATION

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A strong challenge is posed for patients and their caretakers by the growing need for promoting oral healthcare for this population, as research substantiates the connection between oral health and systemic health. This study identified the major barriers to providing optimal oral care to the older population. Fifty patients aged 60 and over visiting visiting the Columbia University College of Dental Medicine Clinic were administered a questionnaire which reflected possible barriers to oral health care. Statistical analysis of data revealed that the top three barriers in order of relevance were the (1) cost of treatment, (2) anxiety, and (3) transportation. The youngest old (60-69) indicated that the lack of time and conflict with work schedules were additional barriers, while the older sample (70+) experienced obstacles due to disability and illness. When gender differences were analyzed, transportation was the most significant as a barrier among males, and fear/anxiety was most significant for females. Ethnically, non-Hispanics indicated that (1) shortage of time, (2) anxiety, and (3) lack of social/physical support were significant barriers. Findings indicated that even those with Medicaid insurance coverage believed that the cost of dental treatment and caregiving responsibilities were major barriers to seeking care. Conversely, even those without dental insurance indicated that disability and illness were barriers to seeking care. This pilot study highlighted various barriers to oral health care and highlighted the need for intervention to address barriers, such as social services, expanded Medicaid coverage, and transportation assistance, to ultimately improve access to optimal oral health care.

LONG TERM OUTCOMES OF THE IN-HOSPITAL MOBILITY INTERVENTION (WALK FOR) IN A SAMPLE OF OLDER ADULTS

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Evaluation of in-hospital mobility programs is usually short-term. To examine the sustainability of Walk-FOR (Walk for Outcome and Recovery), an in-hospital mobility program in internal-medicine older (70+) patients, we conducted a quasi-experimental pre-post four-group comparative study. Walk-FOR incorporated policies encouraging patients to walk more than 900 steps/day and addressed conditions limiting patients’ in-hospital mobility. Self-reported mobility was assessed in intervention (N=159), control (N=154) and two-year follow-up groups: previous-intervention (N=75) and non-intervention (N=95) units. Two-years post-implementation, in previous-intervention units 82.7% of patients reported walking at least twice a day outside their room, similarly to the within-implementation intervention phase (81.2%, p=ns) and significantly more than in the control group (57.2%, p<.0001). No differences in walking were found between intervention and non-intervention units (84.2%, p=ns) two-years post-implementation. Multivariate