primary care can have profound health implications, especially for older adults. Ensuring accessibility to primary care is a key priority in maintaining population health. Understanding the impact of COVID-19 tightening measures on older adults’ primary care utilisation will be useful for future public health planning.

PROFILE OF OLDER PUBLIC TRANSPORTATION USERS IN THE UNITED STATES: IMPLICATIONS FOR AGE-FRIENDLY COMMUNITIES

Afnan Gimie1, Andrea Melgar Castillo2, C. Daniel Mullins3, and Jason Falvey3. 1. University of Maryland School of Medicine, Baltimore, Maryland, United States, 2. University of Maryland School of Pharmacy, Baltimore, Maryland, United States, 3. University of Maryland Baltimore, Baltimore, Maryland, United States

Public buses, trains, and trams are a growing mode of transportation for older adults in the United States, yet many environmental and health related barriers to use have been reported. Characterizing the population of older public transit users is essential for developing age-friendly communities. We used data from 5696 urban, community dwelling older adults in round 5 of the National Aging and Trends Study (NHATS), an annual nationally representative survey of late-life disability. Using SAS (version 9.4), weighted frequencies were calculated and compared between public transit and non-transit users using procedures that account for the complex design of the NHATS survey. Compared to non-transit users, those who reported using transit within the last month (n=555, 9.8%; weighted n=3,122,583) were significantly more likely to identify their race/ethnicity as Black or Hispanic (50% vs 28%) and reported difficulty meeting financial needs for housing, utility, and food (12% vs 7%), and to speak a language other than English (14% vs 8%). Transit users were significantly less likely to use a walker (9% vs 14%) or wheelchair/scooter (4% vs 9%). Additionally, 15% of transit users did not have a working cell phone and 42% did not have a working computer. Over 20% of transit users (weighted n=638,850) rely on these services to get to their doctor. These findings highlight the clinical, social, and financial barriers that disproportionately affect over 3 million older adult transit users in the United States, and inform initiatives oriented towards improving community access for older adults.

REFINING CARFREEME, A DRIVING RETIREMENT PROGRAM FOR PERSONS WITH DEMENTIA AND THEIR CARE PARTNERS

Colleen Peterson1, Katie Louwagie2, Robyn Birkeland2, Stephanie N. Ingvalson3, Lauren Mitchell3, and Joseph Gaugler3. 1. University of Michigan Transportation Research Institute, Ann Arbor, Michigan, United States, 2. University of Minnesota, Minneapolis, Minnesota, United States, 3. Emmanuel College, Boston, Massachusetts, United States

Person living with dementia (PLWD) are at increased risk for roadway crashes and subsequent injury or death. Navigating driving retirement while respecting the PLWD's autonomy and supporting continued independence can be challenging. CarFreeMe™, originally developed in Australia, is a driving retirement intervention providing tailored psychoeducational telecoaching modules to PLWD and/or their care partners. Session topics include living with dementia, balancing independence and safety, adjusting to loss and change, exploring others' experiences with driving retirement, planning for alternative transportation, lifestyle planning, advocacy and support, and problem solving. Phase I enrolled 16 care partners and 11 PLWD. Mixed methods data from Phase I’s 1- and 3-month follow-up surveys and post-intervention interviews demonstrated feasibility and acceptance of CarFreeMe™ with a U.S. audience. Phase I participants found the program valuable and would recommend it to others (96% care partners, 100% PLWD). Care partners and PLWD reported improved Readiness of Mobility Transition scores at the 3-month survey. Several felt the program may be most useful early in the decision making process. The program offered strategies and education that facilitated conversations both during and outside of the intervention sessions to support the PLWD’s agency and acceptance of driving retirement. Participant feedback and lessons learned from Phase I informed Phase II development and deployment. Phase II is enrolling 50 care partners, PLWD, or dyads and includes 3- and 6-month follow-up surveys. Preliminary CarFreeMe™ Phase II utility, acceptance, and driving related outcomes will be discussed as well as next steps for evaluation.

SESSION 4230 (AWARD LECTURE)

DONALD P. KENT AND ROBERT W. KLEEMEIER AWARD LECTURES

Chair: Peter Lichtenberg

The Donald P. Kent Award lecture will feature an address by the 2021 Kent Award recipient Luigi Ferrucci, MD, PhD, FGSA, of the National Institute on Aging. The Kent Award is given annually to a member of The Gerontological Society of America who best exemplifies the highest standards of professional leadership in gerontology through teaching, service, and interpretation of gerontology to the larger society. The Robert W. Kleemeier Award lecture will feature an address by the 2021 Kleemeier Award recipient Kenneth F. Ferraro, PhD, FGSA, of Purdue University. The Kleemeier Award is given annually to a member of The Gerontological Society of America in recognition for outstanding research in the field of gerontology.

DUAL FUNCTIONALITY IN LATER LIFE

Kenneth Ferraro, Purdue University, West Lafayette, Indiana, United States

Longevity and quality of life are core interests in gerontology, but debate has ensued as scholars have sought to integrate the two. I propose the concept of dual functionality to examine how humans reach advanced ages while maintaining both physical and cognitive function. Using a large national sample, my colleagues and I operationalize dual functionality and identify life course factors that predict it. Analyses of 33,310 respondents 50 years or older from the Health and Retirement Study show an estimated median age of 74 for loss of dual functionality. Lifetime stress exposure leads to earlier loss of dual functionality, even after adjustment for socioeconomic status and lifestyle factors.