research addressing their combined implications as well as the mechanisms linking them to various health-related outcomes. Yet, as intersectionality theory reminds us, the consequences of gender, race, immigrant and other inequalities for physical and mental health outcomes must be understood in terms of these overlapping social identities. Moreover, linking intersectionality to stress process theory provides us with an explanation of the mechanisms potentially linking intersecting structural inequalities to health outcomes. This paper draws on data from the Canadian Longitudinal Study on Aging (CLSA - N=51,338) to assess the additive and interactive implications of gender, race and immigrant status for physical and mental health outcomes, together with the mediating effects of primary and secondary stressors on these outcomes. The results of a series of weighted least squares regression analyses suggest that immigrant status interacts with race and/or gender to influence health outcomes. Socioeconomic and other stressors also play a role in linking these intersecting structural inequalities to health outcomes. Overall, our findings provide initial support for the value of linking intersectionality and stress process frameworks for an understanding of the health implications of structural inequalities in middle and later life.

GENTRIFICATION AND CHRONIC CONDITIONS IN OLDER ADULTS: SERVICE PROVIDERS’ PERSPECTIVES
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Where we live impacts our health, but this is more apt for older adults (aged 55+) aging-in-place in their neighborhoods. Gentrification, i.e. the transformation of neighborhoods from low to high value, can put community-dwelling older adults at risk for residential displacement with limited retirement incomes and financial stressors like increased housing costs and property taxes, residential turnover and changing access to resources. As a place-based stressor, gentrification may exacerbate social vulnerabilities (e.g., lower socioeconomic status and racial/ethnic minority status) related to chronic condition (CC) disparities. But, little gentrification research focuses on these issues. This research examines associations between gentrification and older adults’ CC management related to broader social determinants in Hamilton, Ontario, Canada from health and social service providers’ perspectives. Hamilton, a recovering steel industry city with in-migration from Toronto, is experiencing higher costs of living, income inequality and tension with recent gentrifiers. I conducted key informant interviews with service providers in city government and community-based organizations using thematic analysis. Across providers, food insecurity, social isolation and displacement were the biggest issues associated with gentrification and CC, particularly for older adults with lower incomes and government disability support. Results thus far reveal Hamilton has numerous older adult-focused providers, but older adults often have difficulties accessing services due to a lack of knowledge, not always asking or realizing when they need help and coordinated referral difficulties across providers. To address these challenges, providers consider environmental scans, mapping resources and advertisement in an online community information database from the city’s public library.

IMMIGRANT STATUS PREDICTS WORSE SUBJECTIVE MEMORY COMPLAINTS
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The “Immigrant Health Paradox” suggests that immigrants experience better health and lower mortality than the U.S.-born population despite their lower average socioeconomic status. However, it is unclear whether this health advantage extends to all areas of cognitive functioning. This study investigates cognitive functioning and Subjective Memory Complaints (SMCs) as a function of immigrant status and identifies predictors of cognitive decline as well as SMCs among the immigrant population. Data were drawn from the 2010 wave of the Health and Retirement Study. The sample consisted of 9,812 older adults aged 65 and older (8,873 U.S.-born and 939 foreign-born). Logistic regression was used to examine whether immigrant status was associated with cognitive functioning and SMCs, controlling for socio-demographic (age, gender, education, and marital status), health conditions (diabetes, depression, hypertension, and stroke), and functional limitations. Being foreign-born was not a significant predictor of dementia (OR:1.18, 95% CI: 0.83-1.67). However, immigrants were 41% more likely to report SMCs compared to U.S.-born respondents (OR:1.41, 95% CI: 1.17-1.69). Among the immigrant population, immigrants with less than a high school education showed four- and two-times higher odds of having dementia and reporting SMCs than those with more than high school. It is necessary to provide dementia education and screening to immigrants, especially those with low education, as this may contribute to reducing disparities in cognitive functioning within the older population.

MORE THAN MEETS THE EYE: INCOME AND RACIAL DISPARITIES IN VISION HEALTH OF OLDER ADULTS
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By the end of this decade, the USA is projected to experience an increase of more than 50% in the number of people with poorer vision health as the population grows older. Using data from the NHANES III (1988–1994) for 7,186 White, Black, and Hispanic adults of ages 50 to 90 (Mean=68.23, SD=10), this paper examines the racial/ethnic, and socioeconomic disparities in vision health in the older adult population. The focus of this paper is on Visual Impairment indicators: full/partial blindness and trouble seeing with glasses to demonstrate vision health disparities in these race/ethnic groups in terms of family income using logistic regression analysis. Controls include demographic characteristics like age, gender, marital status, region, education and behavioral features like alcohol consumption and smoking. We explore another component of vision health: days since last visit to healthcare provider to evaluate the inequalities in access to health care using OLS regression analysis. In Whites (OR=.85) and Blacks (OR=.63), people with less family income are more likely to experience blindness, however, there exists no significant variability in blindness in terms of family income among Hispanics. In Black (OR=.82) and Hispanics (OR=.85), people with less family income are more likely to have trouble seeing even with glasses, however,
this relationship does not exist among Whites. Days since last visit can be explained by income for Whites (Beta=−.92), not for Blacks and Hispanics. This compounded disparity puts a disproportionate economic burden on minority groups, but the current Medicare policy fails to address that.

PHYSICAL ACTIVITY AS A MEDIATOR IN THE RELATIONSHIP BETWEEN RACE OR ETHNICITY AND CHANGES IN MULTIMORBIDITY

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Racial/ethnic disparities in multimorbidity (≥2 chronic conditions) and their rate of accumulation over time have been established. Studies report differences in physical activity across racial/ethnic groups. We investigated whether racial/ethnic differences in accumulation of multimorbidity over a 10-year period (2004-2014) were mediated by physical activity using data from the Health and Retirement Study (N = 10,724, mean age = 63.5 years). Structural equation modeling was used to estimate a latent growth curve model of changes in the number of self-reported chronic conditions (of nine) and investigate whether the relationship of race/ethnicity (non-Hispanic Black, Hispanic, non-Hispanic White) to change in the number of chronic conditions was mediated by physical activity after controlling for age, sex, education, marital status, personal wealth, and insurance coverage. Results indicated that Blacks engaged in significantly lower levels of physical activity than Whites (b = -.171, □ = -.153, p < .001), but there were no differences between Hispanics and Whites (b = -.010, □ = -.008, ns). Physical activity also significantly predicted both lower initial levels of multimorbidity (b = -1.437, □ = -1.420, p < .001) and greater decline in multimorbidity (b = -.039, □ = -.073, p < .001). The indirect (mediational) effect for the Black vs. White comparison was significant (b = .007, □ = .011, 95% CI [.004, .010]). These results provide important new information for understanding how modifiable lifestyle factors may help explain disparities in multimorbidity in middle and later life, suggesting greater need to reduce sedentary behavior and increase activity.

RELATIVE IMPORTANCE OF POSITIVE AGING DIMENSIONS AMONG LATINO OLDER ADULTS AND SERVICE PROVIDERS

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The variation in Latino older adults’ conceptualizations of positive aging across studies suggests greater attention should be paid to within-group factors. The purpose of the current study was to identify which factors are important to positive aging from the perspective of Latino older adults, and whether the importance of these factors varied based on participant characteristics. A second aim of this study was to examine whether there are differences in views of successful aging between Latino older adults and service providers who support aging Latinos. The current study was conducted as part of a broader research project investigating Latino older adults’ perceptions of positive aging. Latino older adults (n = 93) and aging services providers (n = 45) rated the importance of a series of statements related to positive aging. Mixed-methods analysis of the statements identified nine distinct dimensions (Positive Outlook, Spirituality/Religion, Healthy Behaviors, Independence, Self-Care, Support for Others, Social Support, Leisure Activities, and Adaptability). Latino older adults rated Positive Outlook and Spirituality highest on importance, and ratings differed based on gender and other individual difference characteristics. For example, men placed greater relative importance on Independence and Support for Others compared to women, and younger participants rated Independence higher on importance compared to older participants. In addition, Latino older adults (vs. providers) placed greater importance on all aspects of positive aging, with greatest mean differences related to providing Support for Others and Spirituality. These findings have implications for wellness programs for Latino older adults and training for service providers.