with past medical history of Chronic COPD, Depression, Gait instability, Mild Neuro-cognitive disorder, Hearing Loss, Coronary artery disease. Most significantly he had 3 ED visits, 1 admission, where he was found on the floor of his apartment after two days, by a meals on wheels volunteer. Team conducted a comprehensive assessment of Mr.C's social determinants of health and compiled a care plan. We learned that Mr.C does not like to bother others therefore found it difficult to seek help. Team built intensive rapport and gained his trust to help simplify medications, increase engagement and explore barriers to home care. Mr.C was connected to several community agencies including, meals on wheels for more stable food access, psychiatry to discuss depression and isolation, adult protective services for deep cleaning,financial management, pharmacy for blister packing, home care services and case management to continue encouragement with care plan. Mr.C is now able to reach out to the team as needed and has a navigator to help with managing care. This is one of many cases ALIGN encounters, that often go undetected due to comprehensive inter-professional care needed and minimal time given in traditional primary care.

AGE-RELATED SOCIAL SELECTION AND ITS ASSOCIATED EMOTIONAL AND COGNITIVE COSTS ACROSS ADULTHOOD

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Socioemotional selectivity theory maintains that goal prioritization differs across adulthood as a function of future time horizons. To prepare for a long and nebulous future, young adults prioritize learning and exploration over emotional meaning. Relieved from the burden to prepare, older adults prioritize emotionally meaningful goals. In the context of social relationships, younger adults include proportionally fewer familiar social partners in their social networks, whereas older adults' social networks encompass proportionally fewer unfamiliar social partners. Although social selection is considered adaptive, it inevitably involves gains and losses. The current study examined whether age-related selectivity correlates with (1) greater concurrent negative emotions in younger people, and (2) poorer cognitive performance in old age. A life-span sample (N = 258) completed a social networks questionnaire and cognitive tests. Daily emotional experience was assessed using experience sampling. A subset (N = 119) completed the cognitive tests again five years later. Results of multiple regression analysis, controlling for physical health and trait neuroticism, indicate that smaller proportions of familiar social partners in one's social network correlated with more frequent experience of negative emotions. Age moderated this association with a stronger association in younger than older people. Results of separate multiple regression analysis, controlling for baseline cognition, physical health, age, SES, and trait openness, indicate that a smaller proportion of social partners in one's outer social circle negatively predicted older adults' Digit Span Backward performance assessed five years later. We discuss our findings within the framework of gains and losses in life-span development.

APPLYING ADMINISTRATIVE LINKAGE TO LONGITUDINAL AGING STUDIES: BOSTON EARLY ADVERSITY AND MORTALITY STUDY

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Adverse childhood experiences have been linked to poor adult health, yet the underlying pathways remain unclear. While longitudinal aging studies provide rich data on health trajectories in adulthood, two intrinsic limitations hamper progress in studying causal pathways: (1) reliance on retrospective assessment of early-life conditions, and (2) inadequate data coverage on lifespan developmental processes, especially in childhood. The Boston Early Adversity and Mortality Study (BEAMS) was designed to overcome these limitations by applying high-quality administrative record linkage to three longitudinal studies on aging that are over 50-years-old. BEAMS uses administrative linkage to acquire contemporaneous, early-life information on health, family, and environmental hazards from multiple databases. Our sample includes male participants from the VA Normative Aging (n=2280), Grant (n=456), and Glueck (n=268) Studies. BEAMS extends linkage to siblings, thus including women, so that our combined sample is representative of the early 1900s Northeastern U.S. population. Key steps in administrative linkage include coding identifiers from existing data; linkage to 1900-40 Censes, vital, and military (WWI, WWII, Veterans benefits) records; linkage to public databases for early-life lead exposure data, and later-life health information (Medicare, NDI). By linking records of study participants (74%-94% deceased) to numerous administrative databases, BEAMS will create a cradle-to-grave dataset with prospective data on early socioeconomic, psychosocial, and environmental exposures, and lifespan health data. BEAMS uses human review to achieve high-quality record linkage. Our methodology can be adopted by other longitudinal aging studies to overcome barriers in advancing causal knowledge on pathways linking early-life conditions to lifespan health outcomes.

CHRONIC STRESS AND RISKS FOR MYOCARDIAL INFARCTION IN U.S. ADULTS

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Long-term exposure to stress has been linked to multiple behavioral and biological responses that are detrimental to cardiovascular health, but the association between chronic stress and risks for acute myocardial infarction (MI) remains unknown. We examined the association between exposure to chronic stress and MI incidence from 2006 to 2016 using data from a nationally-representative prospective cohort

study of adults aged 45 and older (n=15,109). Chronic stressors included ongoing issues related to personal health, social relationships, financial strain, housing, and caregiving responsibilities. Cox proportional hazards models were used to examine the association between the number of chronic stressors and MI while adjusting for confounding risk factors. More than half of the respondents reported ≥2 chronic stressors at baseline. Risks for MI increased incrementally from 1 chronic stressor (HR=1.28; 95% CI, 1.20-1.37) to ≥4 chronic stressors (HR = 2.71; 95% CI, 2.08-3.53) compared with those who reported no stressors. These risks were partly attenuated after adjustments for socioeconomic, psychosocial, behavioral, and clinical risk factors. The impact of chronic stressors was especially pronounced among adults with a history of MI (P value for interaction=.032). In adults with a prior MI, risks for a recurrent MI increased substantially from 1 chronic stressor (HR=1.31; 95% CI, 1.10-1.55) to ≥4 chronic stressors (HR = 2.92; 95% CI, 1.47-5.82) compared to those with no stressors. Chronic stress is a significant risk factor for acute coronary events in U.S. adults. More research is required to further understand the psychosocial, behavioral, and biological mechanisms underlying this association.

EQUAL PROTECTION? DIFFERENTIAL EFFECTS OF RELIGIOUS ATTENDANCE ON BLACK-WHITE OLDER ADULT MORTALITY

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Social determinants of later life population health are "the circumstances in which we are born, grow up, live, work, and age" usually identified as power and status determinants: income, wealth, and education. Although rarely considered a social determinant of health, religious social ties are a familiar "circumstance" for many older persons, and there is considerable evidence linking religious attendance to all-cause mortality. There are race differences in both religiosity and mortality patterns: Black Americans show higher levels of both religious attendance and mortality compared with white Americans. This raises the question of equal protection of religious attendance: Is the protective effect of religious attendance on mortality weaker, stronger, or the same for whites and African Americans? The analysis employs 10-year longitudinal data from the Health and Retirement Study, 2004-2014 (N=18,346). In stratified models, after adjustment for sociodemographic factors and health, African Americans have a hazard ratio (HR) for frequent attendance at services that is more protective than for whites: .48 (95%CI: .35, .67) compared with .61 (95%CI: .53, .70). Health behaviors mediate 19% of the effect for blacks and 26% for whites; other social ties mediate 12.5% of the effect for blacks and 7% for whites. An interaction test shows a more protective effect of frequent attendance for blacks compared with whites (p<.000). Religious attendance may be more beneficial for African Americans who are multiply disadvantaged with respect to other social determinants of health. The mediation patterns also suggest that the mechanisms of effect for blacks and whites may differ.

FINANCIAL STRAIN, SELF-RATED HEALTH, AND THE MEDIATING ROLE OF HEALTH BEHAVIORS DURING THE GREAT RECESSION

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Previous research has revealed the physical and mental health consequences of the economic recession that began in 2007 and ended in 2009. Despite accumulating evidence of the harmful health effects of the economic downturn on older adults, relatively little research has examined the mechanisms involved in this relationship. Moreover, most research on the financial crisis has relied on objective indicators of the recession, despite evidence demonstrating the predictive utility of subjective measures such as financial strain. Drawing on a subsample of respondents age 50 or older from the Health and Retirement Study (N = 2040), this research (1) examines whether initial financial strain and that due to the recession independently contribute to worsening self-rated health over the period of the recession and (2) investigates the role of health behaviors as mechanisms in this relationship. Using longitudinal lagged dependent variable models that adjust for pre-recession self-rated health, the results reveal that both initial and increased financial strain due to the recession were associated with worsening self-rated health between 2006 and 2009. In addition, increased financial strain during the recession was found to be associated with skipped or postponed health care visits and change in prescription drug use, such as pill splitting and reduced or skipped doses, which, in turn, were associated with decreased health ratings. The results from this study suggest two important pathways in the recession-health relationship and have implications for policies aimed at supporting older adults during future financial crises.

HIGHER ED AS A LEVELER: HOW EARLY LIFE AND HIGHER EDUCATION SHAPE RESILIENCE AND HEALTH IN ADULTHOOD

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Growing evidence shows that individuals who have high levels of psychological resilience maintain higher levels of physical and psychological health in later life. Individuals cultivate psychological resilience over the life course, yet little research has explored its mechanistic effects on health during midlife. One source of resilience may be formal education, which is a well-established determinant of health in adulthood. Resilience might be one reason for this robust association, as education helps individuals develop greater psychological resources in adulthood. On the other hand, having a college degree also increases access to other health-promoting resources that can be leveraged over the life course, such as better-paying and higher-quality jobs. Using data drawn from the National Longitudinal Study of Adolescent to Adult Health (Add Health), the current paper examines: 1) how early-life factors shape psychological resilience in early adulthood (24-32 years); and 2) the effects of early adulthood resilience on the association between education and health in mid-life (36-44 years). Results show that psychological resilience and