

suggesting that physical functioning declined for some and improved for others. Mental health and fatigue at baseline were both significant predictors of rate of change in physical function ( $p < 0.001$ ), with higher baseline levels of mental health and lower levels of fatigue associated with slower declines in physical functioning over time. Our data suggest that lung cancer survivors may not all experience the same degree of perceived functional declines and those who report lower mental health and higher fatigue may benefit from interventions, such as exercise, to protect against declines in physical functioning.

#### A NEW SCALE FOR ASSESSING OLDER ADULTS' WIRELESS NETWORK PROFICIENCY

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Proficiency with wireless networks (i.e., WiFi) is becoming increasingly necessary to interact with various emerging technologies (e.g., mobile devices, personal internet hotspots). Many component skills for interacting with wireless networks (i.e., configuration, troubleshooting) are often handled by service providers leading to potential gaps in knowledge, adding barriers to researchers administering at-home technology-based interventions. We present and validate a new scale to assess wireless network proficiency of older adults: the Wireless Network Proficiency Questionnaire (WNPQ) and a short-form, 8-question version (WNPQ-8). The WNPQ ( $\alpha = .94$ ), its subscales ( $\alpha$  ranges from .79 to .92), and the WNPQ-8 ( $\alpha = .86$ ), were found to be highly reliable and valid measures of wireless network proficiency in a large sample ( $N = 147$ ). The WNPQ was found to be highly correlated with the CPQ-12 (a measure of computer proficiency, Boot et al., 2014;  $r = .67$ ,  $p < .001$ ) and the MDPQ-16 (a short-form measure of mobile device proficiency, Roque & Boot, 2018;  $r = .76$ ,  $p < .001$ ), and weakly, negatively correlated with age ( $r = -.25$ ,  $p = .002$ ). A similar pattern was observed with the WNPQ-8 (CPQ-12,  $r = .68$ ,  $p < .001$ ; MDPQ-16,  $r = .76$ ,  $p < .001$ ; age,  $r = .26$ ,  $p = .001$ ). WNPQ scores were also found to be predictive of whether a participant can report their WiFi credentials. We conclude that the WNPQ measures may serve as useful tools for facilitating wireless network training of older adults and measuring wireless network proficiency for research purposes.

#### ASSOCIATIONS OF MULTIMORBIDITY COMBINATIONS INCLUDING DIABETES WITH DISABILITY AMONG MIDDLE-AGED & OLDER ADULTS

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Multimorbidity is associated with poor functional status above and beyond the risk attributable to the individual component chronic conditions. Identifying multimorbidity combinations that drive poor functional outcomes among older adults with diabetes is of clinical and public health significance. We used the 2010–2012 Health and Retirement Study data ( $N=3,733$  participants) to identify the most prevalent multimorbidity combinations for middle-aged and older adults with diabetes and estimated binomial regression models to assess the relationship between diabetes-multimorbidity

combinations and prospective ADL-IADL disability. Results show that the three most prevalent multimorbidity combinations were: (1) diabetes-arthritis-hypertension ( $n=671$ , 18%); (2) diabetes-hypertension ( $n=507$ , 13.6%); and (3) diabetes-arthritis-hypertension-heart disease ( $n=344$ , 9.2%). The negative binomial regression results showed that diabetes-multimorbidity combinations that included high depressive symptomatology or stroke had significantly higher counts of ADL-IADL limitations compared to diabetes-only. In head-to-head comparisons of diabetes-multimorbidity combinations, we found that added high depressive symptomatology or added stroke to somatic multimorbidity combinations was associated with a higher count of ADL-IADL limitations (diabetes-arthritis-hypertension-high depressive symptoms vs. diabetes-arthritis-hypertension: IRR=1.88 [1.22, 2.87]; diabetes-arthritis-hypertension-stroke vs. diabetes-arthritis-hypertension: IRR=4.09 [1.56, 10.74]). We conclude that depressive symptoms and/or stroke added onto combinations of other co-existing somatic conditions may pose a substantial functional burden on middle-aged and older adults with diabetes.

#### COHORT BY EDUCATION DIFFERENCES IN LONGITUDINAL CHANGE IN FUNCTIONAL ABILITY

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Quality of life in late adulthood is a function of physical, emotional, and intellectual health, and maintenance of functional ability is central to sustaining independent living. Generational differences in health behaviors and health care may result in differences in how functional ability changes with age. Twenty assessments of functional ability were collected as part of the longitudinal Swedish Adoption/Twin Study of Aging from twins aged 50–88 at the first wave. Participants completed up to 9 assessments covering a 26-year period. Factor analysis was used to create 3 factors: flexibility, fine motor skills, and balance. Individuals born 1900–1924 ( $N=441$ ) were compared with individuals born 1925–1948 ( $N=418$ ). Latent growth curve modeling indicated accelerating changes with age for all 3 factors in both cohorts, but difficulties in motor function increased at a significantly slower pace in the later born cohort. Education was added to the LGCM as an indicator of socio-economic conditions: lower education (elementary school) vs. higher education. Sixty-nine percent of the earlier born cohort and 50% of the later born cohort had only elementary school education. Adding education to the LGCM had no impact on rates of change in the early born cohort. In the later born cohort, however, individuals with less education had the same aging trajectories as the earlier born cohort. That is, only later born individuals with higher educational achievement showed the slower rate of aging of functional abilities. Results demonstrate the SES distinction in the impact of health improvements over the 20th century.

#### DOES ECONOMIC MOBILITY MODERATE THE ASSOCIATION OF CHILDHOOD ADVERSITY WITH ADULT FUNCTIONAL STATUS?

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