lifespan. However, how these early life circumstances cumulatively contribute to depression in old age is not completely understood. The present study examined the associations of eight factors representing multifaceted early life experience at individual, family, and community levels with depression among community-dwelling older adults. Data were from the China Health and Retirement Longitudinal Study. We included 8,239 community-dwelling individuals who were ≥60 years, completed the life history questionnaire, and had assessment of depression. Chi-square test was used to examine the unadjusted associations between each of the eight early life risk factors and depression. An early life disadvantage index was established using risk factors that were significantly associated with depression. Logistic regression was used to examine the association of each early life risk factor and the index with depression. Of 8,239 individuals included, 2,055 (24.9%) had depression. In bivariate analysis, each of eight early life risk factors was significantly associated with depression. Except for maternal and paternal education, all risk factors persisted to be associated with depression after multivariable adjustment. In the multivariable-adjusted model, a one-point higher in the early life disadvantage index (range: 0-6) was associated with a 45% (95% CI: 37%, 53%) higher odds of depression. There was a strong association between early life environments and depressive symptoms among Chinese community-dwelling older adults. Adverse early life circumstances could contribute cumulatively to depression in old age.

COGNITIVE FRAILTY AND ITS LONG-TERM EFFECT ON DEPRESSION IN AN OLDER POPULATION IN KOREA

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Cognitive frailty is a condition where physical frailty and mild cognitive impairment (MCI) co-exist without dementia. It occurs in 1.8%-8.9% of the general older population, and older people with depression have a higher risk of frailty. However, the relationship between cognitive frailty and depression is still unclear. This study aimed to determine the relationship between cognitive frailty and depression of older adults by time using comparative group analysis. A secondary analysis was conducted using the Korean Longitudinal Study of Aging (KLoSA) dataset from 2010 to 2018. A sample was 981 older adults who were 65 years old and without dementia over residing in the community. Cognitive frailty was defined as having a mini-mental state examination score of 18-23 and 3 or more of the Fried frailty indexes. Generalized Estimating Equation model and chi-square test were employed. Of the 981 subjects, the cognitive frailty(CF) was 28.5%, followed by robust (37.7%), physical frailty (PF, 29.4%), mild cognitive impairment (MCI, 4.4%) at baseline. The group differences on depression measured by the Center for Epidemiological Studies Depression (CESD) were statistically significant in the PF (F=4.70, p<.001) and the CF (F=4.95, p<.001) group compared to the robust group. The time difference effect (F=.09, p=.05) and a group-by-time interaction effect were observed (p<.001). This study confirmed that cognitive frailty is strongly associated with depression. Effective approaches to managing psychological wellbeing, including dementia, are essential for older adults with cognitive frailty.

DEPRESSION AND AGE-RELATED CHANGES IN BODY COMPOSITION, CARDIOVASCULAR FUNCTION, GRIP STRENGTH, AND LUNG FUNCTION

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Individuals with mental disorders, on average, die prematurely, have higher levels of physical comorbidities and may experience accelerated ageing. In individuals with lifetime depression and healthy controls, we examined associations between age and multiple physiological measures. The UK Biobank study recruited >500,000 participants, aged 37-73, between 2006–2010. Generalised additive models were used to examine associations between age and grip strength, cardiovascular function, body composition, lung function and bone mineral density. Analyses were conducted separately in males and females with depression compared to healthy controls. Analytical samples included up to 342,393 adults (mean age = 55.87 years; 52.61% females). We found statistically significant differences between individuals with depression and healthy controls for most physiological measures, with standardised mean differences between -0.145 and 0.156. There was some evidence that age-related changes in body composition, cardiovascular function, lung function and heel bone mineral density followed different trajectories in individuals with depression. These differences did not uniformly narrow or widen with age. For example, BMI in female cases was 1.1 kg/m2 higher at age 40 and this difference narrowed to 0.4 kg/m2 at age 70. In males, systolic blood pressure was 1 mmHg lower in cases at age 45 and this difference widened to 2.5 mmHg at age 65. Individuals with depression differed from healthy controls across a broad range of physiological measures. Differences in ageing trajectories differed by sex and were not uniform across physiological measures, with evidence of both age-related narrowing and widening of case-control differences.

WAYS COMMUNITY-BASED ORGANIZATIONS ENHANCE LATE-LIFE DEPRESSION CARE IN PARTNERSHIP WITH CLINICS

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Late-life depression is a serious public health concern in the U.S., especially as the population ages. To improve care coordination and increase the number of providers working to improve depression outcomes, primary care clinics and community-based organizations (CBOs) can partner and improve care. Addressing social determinants of health is one area CBOs can help respond to but there are other ways CBOs can bring value to these partnerships with primary care clinics. As part of a qualitative evaluation of the Care Partners Project, 84 key informant interviews and 20 focus groups were conducted over five years with selected primary care physicians, care managers, administrators and psychiatric consultants. These data were coded and organized using an inductive and deductive thematic analysis

approach. CBOs contributed to care through 1) adding new services that focus on clients' social needs (e.g., assistance locating affordable housing, reliable transportation, applying for social security benefits) that were foundational to effective depression care; 2) strengthening core aspects of existing care; 3) incorporating a lay health workforce to enhance care; and/or 4) adding home visits that supported deeper understanding of patient's life context, enhanced trust and improved access to care. CBOs can enhance depression care through increasing access and quality of care. Findings can inform conversations about the value CBOs offer when partnering with health care systems and improve partnership efforts. Such conversations are worth revisiting as organizations deepen their connections and work together over time.

Session 4055 (Paper)

Developmental Challenges in Later Life

DIFFERENTIAL TREATMENT OF OLDER WORKERS DUE TO COVID-19: POTENTIAL FOR AGEISM AND AGE DISCRIMINATION AT WORK

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This paper examines the implications of employers' current COVID-19 protective workplace attendance policies toward older workers, potentially creating the outcomes of increased numbers of involuntary retirees and the discouraged older worker syndrome among otherwise qualified older workforce participants. How potential ageist assumptions and age discrimination under COVID-19 affect workplace decisions in reflection on the Age Discrimination in Employment Act (1967) guidelines is discussed. Older workers may remain in the workforce longer than ever before due to having healthier life expectancies. Workplace policies need to be increasingly sensitive to older employees' rights to sustain their workplace engagement (Cummins, 2014; Cummins, Harootyan, & Kunkel, 2015). The author reviewed current unemployment trends in 2020 and emerging litigation in reflection upon general issues of COVID-19 related age discrimination in the older workers' workplace attendance decisions by employers and the historical framework of the Age Discrimination in Employment Act (1967, with significant amendments in 1978 and 1986). The policy analysis paper presents the implications of employers' COVID-19 protective policies on older workers and how it may affect the "health" of the workplace and older adults and the economy beyond the pandemic. Lastly, strategies to address an "age-friendly" workplace during a pandemic and post-pandemic are discussed.

EARLY RETIREMENT AND SENSORY IMPAIRMENTS: THE MODIFYING EFFECT OF TOTAL ASSETS

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Sensory impairments are common among older adults. Little is known on the association between sensory impairments, which impact labor productivity, and the effect modification of wealth. We used the 2006-2018 rounds of the Health and Retirement Study. Hearing (HI) and vision (VI) impairments (self-report) at baseline, and working status throughout the study period was observed. Logistic regression models, adjusted for demographic, socioeconomic, and health characteristics, were used to characterize the association of sensory impairment and early retirement (i.e., before age 65). Secondary analysis stratified by assets. Among 1,688 adults ages 53-64, 1,350 had no impairment, 140 had HI only, 141 VI only, and 57 had dual sensory impairment (DSI). Only adults with HI had higher odds of early retirement (Odds Ratio [OR]: 1.6; 95% Confidence Interval [CI]: 1.0,2.5) relative to those without sensory impairment. Among those with large assets, those with HI had higher odds (OR:2.6, 95% CI: 1.4,5.2) and those with VI had lower odds (OR. 0.37; 95% CI: 0.2,0.8) of early retirement. Among the low asset group, we found no differences across impairment groups for the odds of retirement. In sample of older adults, we provide evidence that the presence of hearing impairment is associated early retirement. Secondary analyses suggest wealth may modify this association which highlights the wealth disparities faced by people with sensory impairments.

ELDERCARE RESPONSIBILITIES AND PHYSICAL HEALTH SYMPTOMS AMONG MANUFACTURING WORKERS

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Working adults responsible for providing care to older relatives at home (eldercare) have reported greater psychological health problems such as depressive symptoms and stress than workers without eldercare responsibilities. Less is known about how eldercare is associated with physical health symptoms such as sleep-related problems and pain. Among manufacturing workers, such physical health symptoms have the capacity to diminish productivity. Therefore, we explored associations between eldercare responsibilities and physical health symptoms that could affect work performance in a sample of 357 adult employees from five manufacturing companies in a northeastern US state. Research questions were: are workers with eldercare responsibilities more likely than those without eldercare responsibilities to report sleep-related and pain-related symptoms, and are the number of eldercare tasks associated with these physical health symptoms? Among sample members, 52 (14.6%) provided eldercare, 62% were male, mean(standard deviation) age=49.8(12.7), and 77% were non-Hispanic White; no demographic differences were found between those with and without eldercare responsibilities. In bivariate analyses, we found that providing eldercare was associated with lower sleep quality (p=.05), fewer hours of sleep during the workweek (p=.04), more pain interference at home and at work (p=.02), and more pain on average in the past week (p=.01). Providing more types of eldercare tasks ranging from personal care to providing transportation was associated with more pain on average in the past week (p = .04). We conclude that eldercare is associated with physical health symptoms that could directly affect job performance among