

assessed with the Mini-Mental Status Exam (MMSE), Trails B and category fluency, and reassessed in 1992-96. In this sample, rates of egg consumption ranged from never (14.0% of men, 16.5% of women) to ≥ 5 /week (7.0% of men, 3.8% of women; $p=0.0013$). Mean 1988-91 cognitive function scores for men vs. women were 27.5 vs. 27.7 on the MMSE ($p=0.08$), 105.9 vs. 121.6 on Trails B ($p<0.0001$), and 20.2 vs. 18.2 on category fluency ($p<0.0001$). Sex-specific regression analyses examined associations of egg consumption with change in cognitive function. In women, after adjustment for age and education, egg intake was associated with less decline over time in category fluency ($\beta=-.10$, $p=0.01$), which remained significant after adjustment for smoking, alcohol, exercise, cholesterol, calorie intake, and protein intake ($p=0.02$). No other associations were found in women, and no associations were observed in men before and after adjustment for covariates. Results suggest that while high in dietary cholesterol, egg consumption is not associated with decline in cognitive function. For women, there may be a small beneficial effect for verbal memory.

ERECTILE FUNCTION, SEXUAL SATISFACTION, AND COGNITIVE DECLINE IN MEN FROM MIDLIFE TO OLD AGE

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We investigated how changes in erectile function and sexual satisfaction relate to cognitive decline in men from midlife into early old age. This is a major transitional period for increased incidence of erectile function and for cognitive decline. We examined 833 men from the Vietnam Era Twin Study of Aging whose mean ages were 56, 61, and 68 at the time of assessment. Erectile function and sexual satisfaction were measured using scores from the International Index of Erectile Function. Individuals with erectile dysfunction at baseline were excluded. Cognitive performance was measured using factor scores for separate domains of episodic memory, executive function, and processing speed. We tested linear mixed models hierarchically adjusted for demographics, sexual activity, as well as physical and mental health confounders to examine how changes in erectile function and sexual satisfaction related to changes in cognitive function. Declines in erectile function were associated with declines in episodic memory ($p=.004$, $d=.25$), while declines in sexual satisfaction were associated with declines in processing speed ($p=.006$, $d=.19$). Decreasing erectile function and sexual satisfaction may be indicative of individuals also likely to be facing cognitive decline. Possible mechanisms accounting for these changes may include white matter microvascular disease and/or various lifestyle influences. Discussing and tracking sexual health with middle aged men may be a crucial step in identifying those likely to face cognitive decline.

EXAMINING THE IMPACT OF COVID-19 ON LONELINESS AND SOCIAL ISOLATION AMONG AFFORDABLE HOUSING RESIDENTS

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Loneliness and social isolation are serious public health concerns associated with higher risks of clinical depression, suicidal ideation, coronary artery disease, stroke, functional decline, an increased risk of developing dementia and cancer mortality. Recent reports indicate the prevalence and dangers of loneliness and social isolation have increased as a result of the COVID-19 pandemic, especially among older populations. In order to address these concerns among residents living at Northgate II (NGII), a 302-unit affordable housing development in Camden, NJ, Fair Share Support Services, Inc. (FSSS), the non-profit arm of Fair Share Housing Development, collaborated with the New Jersey Institute for Successful Aging (NJISA) and the DHHS-funded Geriatric Workforce Enhancement Program (GWEP) to develop a loneliness/social isolation survey using two evidenced-based tools, the UCLA Loneliness Scale and the Steptoe Social Isolation Index. FSSS piloted the loneliness and social isolation survey with 192 low-income minority older adults residing at NGII. Results indicate that 49% of the NGII residents surveyed fall into 5 "at-risk" categories: 1) lonely and isolated (9%), 2) lonely/somewhat isolated (8%), 3) lonely/not isolated (9%), 4) isolated/somewhat lonely (9%), and 5) isolated/not lonely (14%). FSSS will utilize survey results and follow-up interviews to tailor social service/other interventions to meet the needs and preferences of residents with the goal of preventing serious health problems associated with loneliness and social isolation, allowing residents to age in place.

EXAMINING THE IMPACT OF INDIVIDUAL AND SHARED BIOLOGICAL RISKS ON HEALTH AMONG OLDER MARRIED COUPLES

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Relationship research has suggested that health among spouses is interdependent and should be considered jointly. Using data from the 2008/2010 and 2016/2018 waves of the Health and Retirement Study (3858 qualified couples; age= 67.0 ± 9.6), we investigated the joint influence of married partners' individual and shared cumulative biological risk on future health outcomes. Two risk indicators were constructed to indicate biological health in different domains. Individual grip strength, walk speed, lung function, and cystatin-C were biomarkers selected to construct frailty risk whereas blood pressure, pulse, waist circumference, C-reactive protein, glycohemoglobin, high-density lipoprotein cholesterol, and total cholesterol were biomarkers used to construct cardiometabolic risk. Shared risk was calculated as the number of risks the partners shared. We employed multilevel Poisson regression models to nest partners within couples and examine the effects of individual and shared cumulative risks on future functional limitations. Heckman correction was performed to correct potential selection bias. Our unadjusted models showed individual (frailty: $b=0.22$, $p<.001$; cardiometabolic: $b=0.10$, $p<.001$) and shared (frailty: $b=0.17$, $p<.001$; cardiometabolic: $b=0.08$, $p<.01$) risks are associated