had lower odds of reporting fair or poor health, (aOR=0.43, 95% CI=0.2-0.9). For transgender participants, Hispanic and Other Race adults had approximately twice the odds of reporting fair or poor health compared to White adults (aOR=2.1, 95% CI=1.2-3.7, and aOR=1.9, 95% CI=1.2-3.0, respectively).In conclusion, the results of this study suggest that cultural differences in racial/ethnic groups may influence the health of the LGBT community, making it an important factor to consider in research on LGBT older adults.

HEALTHCARE DISPARITY AND COMORBIDITY BURDEN IN HEART FAILURE PATIENTS OVER THE AGE OF 80

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The healthcare industry is currently struggling with providing access and coverage for a rapidly ageing and increasingly diverse population with multiple co-morbid conditions. This retrospective study analyzed the electronic health records of elderly heart failure patients (age range 80-103; mean 87 ±4.9) for common co-morbid conditions of hypertension, hyperlipidemia, dementia and diabetes mellitus. Chart review analysis of 316 patients showed a racial distribution of 251 White vs. 65 Black patients (79% vs. 21%). Male patients were under-represented (B= 13.8% and W= 26.3%). Females patients predominated (B= 86.2% and W= 73.7%). Overall, the prevalence of all four comorbidities was approximately three times higher in Blacks (18.5%) vs. White (7.2%). The proportion of Blacks and Whites with HTN and was comparable at 98.5 and 92.4% respectively. Hyperlipidemia was present in 84.6% Black and 63.3% White. The diagnosis of diabetes was higher in Blacks, 41.5% compared to Whites, 21.9%. The greatest disparity was in the diagnosis of dementia which was higher in Blacks, 61.5% vs Whites, 44.6%. Our study is unique for studying healthcare disparity in octogenarian and nonagenarian residing in a rural setting. Our results also highlight the importance of making a special effort to engage older Black patients in seeking healthcare in addition to designing strategies to reduce barriers that impede access and availability of resources and clinical care, especially in economically underserved regions of the country.

IMPACTS OF SOCIAL CAPITAL FACTORS ON BLOOD GLUCOSE CONTROL AND DEPRESSIVE SYMPTOMS

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Social capital, conceptualized as resources arising from social networks, is receiving increased attention for its role in prevention and management of chronic conditions such as diabetes and depression that commonly co-occur. Although social capital has been linked to control of blood glucose and depression, previous research has not considered these two outcomes simultaneously while distinguishing between cognitive (i.e., perceived social support, shared values and trust in community) and structural (i.e., social connectedness and participation) domains. This study examined how these two domains of social capital relate to glucose control and depressive symptoms, and whether physical exercise and care access mediate those relationships, using structural equation modeling. The sample included 3,043 older adults aged 57 and above from wave 2 of the National Social Life, Health and Aging Project. Although a higher level of cognitive social capital was associated with higher levels of physical exercise (b=.38, p<.001), access to care (b=.40, p=.007), lower levels of blood glucose (b=-.43, p<.001) and depressive symptoms (b=-.84, p<.001), a higher level of structural social capital was associated only with a higher level of physical exercise (b=.16, p=.002). The mediating effects of physical exercise and access to care were not significant. Findings suggest that cognitive social capital may have greater influence on blood glucose and depressive symptoms than structural social capital, and therefore have different implications for practice, especially in the context of pandemic-related disruptions to social capital. Future research should examine other mediators and investigate how promotion of cognitive social capital might improve health outcomes.

IS RESILIENCE PROTECTIVE OF MOVEMENT-EVOKED PAIN IN OLDER BLACK WOMEN WHO EXPERIENCE DISCRIMINATION?

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Older non-Hispanic black (NHB) individuals experience greater pain and more frequent experiences of perceived discrimination compared to non-Hispanic white individuals with knee osteoarthritis. The current study explored whether being resilient buffers against movement-evoked pain (MEP) in NHB women who report everyday experiences of discrimination. In a secondary analysis of the Understanding Pain and Limitations in Osteoarthritic Disease (UPLOAD-2) study, data were collected at the University of Florida and the University of Alabama at Birmingham. Participants were 58 community-dwelling older women who self-identified as NHB and reported knee osteoarthritis. Participants completed the Brief Resilience Scale, a self-report measure of trait resilience. MEP was assessed following the Short Physical Performance Battery. Moderation analyses were conducted to investigate whether resilience moderates the association between experiences of discrimination and MEP. Study site, age, body mass index, and income were included as covariates. Overall, neither everyday experiences of discrimination (b=.292, 95% confidence interval [CI]=-.415 to 1.000) nor trait resilience was associated with MEP (b=-11.540, 95% CI=-23.583 to

.503). However, there was a significant interaction (b=1.037, 95% CI=.150 to 1.925) between experiences of discrimination and trait resilience in predicting MEP. Simple slopes analysis revealed that lower discrimination was associated with lower MEP, but only in women who reported high levels of resilience (b=1.100, p=.014), but this protective effect of resilience was absent in women reporting high discrimination. Our findings suggest that as discrimination increases, the protective effects of resilience on movement evoked-pain decreases. Therefore, high trait resilience may be protective when experiences of discrimination are low.

LINKING SLEEP AND RACIAL HEALTH DISPARITIES: CHARACTERIZING SLEEP IN THE NATIONAL SLEEP RESEARCH RESOURCE

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To address the problem of racial health disparities, prior work has studied differences in environmentally-influenced and modifiable health behaviors, like nutrition and physical activity. Mounting evidence suggests that sleep plays a key role in health, including cardiometabolic and neurodegenerative disease. Thus, studies have begun to characterize sleep differences across racial groups. We aimed to better quantify differences in objective sleep that may contribute to racial health disparities. In preliminary analyses, we examined whole-night polysomnography from 728 individuals between the ages of 7 and 86 (M: 41.39, SD: 19.39) in the diverse Cleveland Family Study (45% males, 57% African Americans; AAs). Linear models examined racial differences in a battery of sleep metrics and tested interactions with age. Microarchitecture metrics included NREM spindle and slow oscillations, important to cognitive-aging and cardiometabolic health. AAs spent relatively more time in lighter N2 (b= 0.295, p<.001) and less time in deeper N3 (b= -0.364, p<.001) sleep. AAs also had lower NREM spectral power across multiple frequency bands (p<.001), and reductions in spindle characteristics including amplitude (b = -0.537, p<.001) and density (b = -0.341, p<.001). Metrics showed qualitatively different patterns of interaction with age: e.g., racial differences in N3 duration increased with age, and differences in spindle amplitude decreased with age (interactions p<.001), despite marked age-related reductions across all individuals. This work may help to identify specific modifiable aspects of sleep as targets for ameliorating health disparities. Patterns of racial differences over the lifecourse may illuminate different mechanisms being active at different points in development.

MULTIMORBIDITY AMONG DIVERSE COMMUNITIES IN NEW ENGLAND: FINDINGS FROM THE HEALTHY AGING DATA REPORTS

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The risk for multimorbidity increases with age. Community burden of comorbidities in New England (NE) was assessed by comparing state and community rates of two measures (having no comorbidities and having 4 or more) among Medicare beneficiaries age 65+ in CT, MA, NH, and RI. Data sources were the Medicare Current Beneficiary Summary File (2014-2017) and the American Community Survey (2014-2018). Small area estimation techniques were used to calculate age-sex adjusted community rates. Multimorbidity was measured as people with zero or with 4 or more of the following chronic conditions: Alzheimer's disease, asthma, atrial fibrillation, cancer (breast, colorectal, lung, and prostate), kidney disease, COPD, depression, diabetes, congestive heart failure, hypertension, hyperlipidemia, ischemic heart disease, osteoporosis, arthritis, and stroke. Rates for 4+ conditions: RI 63.8% (45.76-70.69%), CT 61.8% (47.82-70.05%), MA 60.7% (40-74.96%), NH 54.4% (36.67-62.99%). Results were mapped, showing the statewide and regional distribution of rates. Rates were much higher for having 4+ chronic conditions than not having any comorbidities. RI had the highest rates of 4+ and in MA the highest chronic disease rates were found in lower socioeconomic communities. CT has the highest number of diverse older residents and dual-eligible beneficiaries for Medicare and Medicaid in NE. The rates show late-life health disparities that have implications for independent living, quality of life, and mortality suggesting the need for policies to provide equitable access to care and resources to disadvantaged NE communities.

NEEDS ASSESSMENT OF PERIMENOPAUSE RESOURCES AND SERVICES

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Studies show that women lack knowledge about perimenopause and feel unprepared to make healthcare decisions during this life transition. Most women want to be involved in their healthcare decisions and need timely, free, and accurate information. We conducted a needs assessment in Douglas County, Kansas by systematically reviewing regional organizations that might offer services and resources related to women's health in midlife. We compared these resources to a benchmark for menopausal care available online nationwide (Gennev.com). We documented the primary purpose of each organization (e.g., cosmetic, wellness, medical care), services and resources offered (e.g., hormone therapy, counseling, non-pharmacological treatments), methods of outreach (e.g., blogs, classes), target audience, costs, and types of service providers (e.g., physician, counselor). We surveyed 9 regional websites: 5 offered medical care, 3 cosmetic and wellness services, 2 were municipal organizations, 2 offered mental health/social support. Four organizations offered services targeted specifically towards perimenopausal women. The most commonly offered services were hormone replacement therapy (44%), nutritional supplements (33%), and weight loss programs (33%). Very few offered educational resources (1) or menopause assessments (1) and none offered tailored psychosocial support for the perimenopause