organization and cultivate stronger connections with other members over time. Our findings inform how to recruit and retain members in Villages, and customer-driven organizations for older adults more broadly.

RESIDENTIAL ENVIRONMENT, DEPRESSIVE SYMPTOMS, AND ANXIETY SYMPTOMS AMONG COMMUNITY-LIVING OLDER ADULTS

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Past literature has suggested significant relationships between neighborhood environment and mental health of older adults. However, the effect of residential environments is underexplored. The present study aims to study: (Q1) how residential built environments are associated with depressive and anxiety symptoms among community-living older adults, and (Q2) whether the associations of their physical and cognitive health status with mental health vary by residential environments. We analyzed data from Round 9 of National Health and Aging Trends Study. Residential environments were indicated by home despair, cluttered home, and existence of entrance ramp. Covariates included age, gender, race, living arrangement, ADL limitations, physical capacity, and cognitive status. The logistic regression results show that higher levels of clutter at home and the lack of entrance ramp were significantly associated with more depressive symptoms and that levels of clutter were positively associated with anxiety symptoms. Residential environments significantly moderated the association between physical health and mental health. With similar physical capacity, older adults with higher levels of home despair and clutter had more depressive and anxiety symptoms. Older adults who had more cluttered home reported significantly higher levels of anxiety than those who had similar ADL limitations, but lived in a less cluttered housing environment. However, we didn't find any moderating effect of residential environments on cognitive impairment and mental health. Our findings promote the necessity for practitioners and policymakers to consider the effect of residential environments on mental health among both physically healthy and impaired older adults in the United States.

SOCIAL ROLES OF FAMILY AND FRIENDS DIFFER IN SOCIAL NETWORKS OF OLDER ADULTS WHO LIVE ALONE

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Social networks consisting of family and friends tend to better facilitate older adults' emotional well-being than networks consisting of only family or only friends. This study assessed the heterogeneity of older adults' network compositions based on the network members' relationship (family vs. friends) and proximity (local vs. non-local) and evaluated the types of interactions between older adults and types of members. Adults 60 years and older living in a U.S. Midwestern city participated in a one-time structured survey (n=133), and reported about 1,730 social network members. Compared to participants who lived with others, those who lived alone reported more depressive symptoms and higher frequency of feeling lonely (p=0.002). Those who lived alone also had higher proportions of local friends in their networks than those who lived with others (p=0.02). Whereas the social roles of family and friends were similar in networks of older adults who lived with others, those who lived alone were less likely to identify family as who they co-engaged in social activities with (local family OR=0.55, non-local family OR=0.27) and who provided companionship (local family OR=0.33, non-local family OR=0.11) compared to their local friends. Having more members who co-engaged in activities was associated with lower depressive symptoms (p=0.05) and less frequency of feeling lonely (p<0.01). Providing supportive infrastructure for community-based older adults to develop and maintain co-engaging relationships with local friends may be beneficial. Network approaches can be used to identify existing network members who may be inspired to play this role.

UNDERSTANDING MULTIDISCIPLINARY-TEAM PRACTICE IN DEVELOPING HOME ASSESSMENT TOOLS: A SYSTEMATIC REVIEW

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As widely used instruments to identify risk factors and lay out preliminary plans of how to improve the built environment, home assessment tools play an important role in the process of modifying homes for older adults. Developed by a variety of disciplines and tailored to meet various needs, home assessment tools focus on features in homes and how they meet or hinder an older person's ability to accomplish tasks — in other words, person-environment fit. Based on a comprehensive review of ten evidence-based home assessment tools identified by researchers at the USC Leonard Davis School of Gerontology and the National Council on Aging, we found that a common assessment strategy is the use of multidisciplinary teams (MDTs) in developing and testing the assessment tools to ensure the reliability vs validity of different home modification programs. To understand the nature of MDT practice and derive a set of generalizable protocols for developing person-centered home assessment tools, we conducted a systematic analysis of the ten evidence-based home assessment tools and 41 peer-reviewed journal papers about how the tools were developed, used, and modified. In addition, we applied the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) to examine the use of MDTs in developing the tools and carrying out the programs. Based on our analysis, we propose a set of preliminary protocols for developing home assessment tools and a logic model for conducting person-centered home modification programs.

VALIDATION OF A MEASURE OF LONELINESS FOR HOMEBOUND OLDER ADULTS

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The pandemic has disproportionately impacted older adults, highlighting the need to address social isolation for this population. Homebound older adults are at risk for loneliness, which is a correlate of poor mental and physical health. COVID-19 has exacerbated effects of social isolation by limiting contact with family and other visitors. In-depth empirical validation of loneliness scales is needed to examine the measurement of this construct for homebound older adults who are aging in place. This study examined the reliability and validity of the UCLA Loneliness Scale (v3) for a community-dwelling population of older adults who received home-based support services due to their homebound status or have chronic illness resulting in ADL limitations. Using in-home interviews, data were collected for 175 older adults using the UCLA Loneliness Scale. Reliability and confirmatory factor analyses were conducted to examine its psychometric properties. Findings demonstrated the scale had good internal consistency reliability ($\alpha = 0.91$). Confirmatory factor analyses indicated a two-factor solution, 1) disconnectedness and 2) connectedness, accounting for 92% of the variability in the 20 items. The lack of meaningful relationships ($\lambda = 0.73$, $p < 0.05$) or having someone to turn to ($\lambda = 0.68$, $p < 0.05$) substantively contributed to disconnectedness. Feeling that there were people to talk to ($\lambda = 0.67$, $p < 0.05$) and turn to ($\lambda = 0.76$, $p < 0.05$) contributed to connectedness. Future research can further examine how quality of relationships and benefits of being connected to others can address loneliness and isolation for this population.

WHO AND WHERE? THE SPATIAL CONTEXT OF RACIAL AND ETHNIC DISPARITIES IN ECONOMIC SECURITY AMONG OLDER ADULTS

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Many older adults experience challenging financial circumstances and do not have sufficient income to afford a basic budget in their home communities. Far higher proportions of racial and ethnic minority older adults live on incomes that fall short of what is needed to make ends meet relative to their White counterparts. We describe racial/ethnic disparities in late-life economic insecurity, which occurs when an older person lacks sufficient financial resources to cover necessary expenses in their home community. Although nationwide half of older singles are economically insecure, Massachusetts (62%), New York (65%), Vermont (57%), and Mississippi (57%) have the highest shares of older adults who experience economic insecurity. Compared to Whites, minority older adults have higher rates of economic insecurity in nearly every state, but racial/ethnic disparities are higher in some locations (Rhode Island, Massachusetts, Mississippi, Louisiana) and lower in others (Oregon, Arizona, Nevada, West Virginia). Disparities in economic insecurity reflect the precarious financial situations experienced by many older adults, rooted not only in risks and disadvantages accumulated over time, but also in the variable and uncertain social and economic contexts that accompany the aging experience. By situating older adults in their places of residence, we observe that the cost of remaining in community intersect with life-course experiences associated with social identities to produce disparities in economic security at older ages. The geographic variation in cost of living calls for context-specific assessment of economic security to evaluate the adequacy of economic resources and the associated risk of hardship.

Session 9045 (Poster)

Aging, Diversity, and Health Equity

A FOOD BOX INTERVENTION TO REDUCE BLOOD PRESSURE IN NATIVE AMERICAN ADULTS WITH HYPERTENSION: THE CHEERS STUDY

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Diet-related chronic diseases, such as hypertension and obesity, are prevalent in Native American (NA) communities where poor food environments are prominent and healthy food access is limited. The Chickasaw Healthy Eating Environments Research Study (CHEERS) is an NIH-funded study aimed to improve Body Mass Index and blood pressure control among NA adults with uncontrolled hypertension. This multi-level randomized trial, guided by a community-based participatory research orientation, was co-created by tribal and university partners and is implemented within the Chickasaw Nation of Oklahoma. We created hypertension-specific food boxes that contained DASH diet foods, coupons for purchasing vegetables and fruits, educational materials, and heart-healthy recipes for supporting healthy eating. Food boxes were packed and shipped monthly to intervention participants with a 30-day supply of: one fruit serving/day, one vegetable serving/day, one serving of unsalted nuts or seeds/day, one serving of beans or lentils/day, and two servings of fatty fish/week. We will present our participatory approach in co-developing the CHEERS study methods, findings with a focus on older adults, and lessons learned. CHEERS is the first innovative food box intervention to be conducted in NA communities. Food box interventions show promise in improving dietary intake and reducing hypertension and obesity in rural and poor food environments.

A RELATIONSHIP-ORIENTED MODEL OF RESEARCH PARTICIPATION: THE BRAIN HEALTH COMMUNITY REGISTRY

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