to non-caregivers. For both caregivers and non-caregivers, having a volunteer role increased well-being, while paid employment was not significantly associated with well-being. Social isolation mediated neither employee nor volunteer role with well-being for both caregivers and non-caregivers. Assuming that volunteering for others without monetary compensation brings meaning in life, this finding supports the provision of services (e.g., respite care) that could supplement caregiving time, allowing caregivers to have more freedom to use the time in such community-engaging roles. Even though self-rated health was controlled, there is a chance that healthier individuals engage in productive roles. Thus, reciprocal relationships between productive roles and health should be considered in future investigations.

SESSION 2825 (PAPER)

SOCIAL DETERMINANTS OF HEALTH

A CONFLUENCE OF POLICY INEQUALITY: HEALTH DISPARITIES IN OLD AGE AMONG AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS

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Racial health disparities in old age are well established, and new conceptualizations and methodologies continue to advance our understanding of health inequality across the life course. One group that is overlooked in many of these analyses, however, is the aging American Indian/Native Alaskan (AI/NA) population. While scholars have attended to the unique health inequities faced by the AI/NA population as a whole due to its discordant political history with the US government, little attention has been paid to unique patterns of disparity that might exist in old age. I propose to draw critical gerontology into the conversation in order to establish a framework through which we can uncover barriers to health, both from the political context of the AI/NA people as well as the political history of old age policy in the United States. Health disparities in old age are often described through a cumulative (dis)advantage framework that offers the benefit of appreciating that different groups enter old age with different resources and health statuses as a result of cumulative inequalities across the life course. Adding a framework of age relations, appreciating age as a system of inequality where people also gain or lose access to resources and status upon entering old age offers a path for understanding the intersection of race and old age. This paper will show how policy history for this group in particular as well as old age policy in the United States all create a unique and unequal circumstance for the aging AI/NA population.

A SCREENING AND REFERRAL INTERVENTION FOR FOOD INSECURITY AMONG OLDER EMERGENCY DEPARTMENT PATIENTS

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Food insecurity is prevalent among older adults, negatively impacts health, and may increase healthcare utilization. Risk factors include poverty, lack of transportation, and social isolation. Community-based services may mitigate food insecurity and other social risk factors. However, identifying those at risk and connecting them to services can be challenging. We implemented a screening and referral program in an Emergency Department (ED) to identify older adults facing food insecurity and connect them to a local Area Agency on Aging (AAA), which arranged and tracked delivery of community-based services. ED nursing assistants used the Hunger Vital Sign screener to assess food insecurity in patients aged 60 years and older. ED Care Managers (CMs) saw all who screened positive and made referrals to the AAA. The AAA conducted an intake assessment and arranged services. Patients were contacted three months after their ED visit to evaluate health, quality of life, and satisfaction with services. Of 423 patients screened over 7 months, 45 (11%) reported food insecurity. Of those, 25 were referred to the AAA. Patients were not referred to the AAA due to CM inability to make a referral (7), declining services (4), or other reasons (11). The AAA reached 21 patients and 9 received at least one service. Of those, 5 were reached for follow-up and reported satisfaction with services. The most frequently requested service was Meals on Wheels (10). Food insecurity is common among older ED patients. An ED-AAA partnership is feasible and connects older adults to beneficial services in their communities.

FOOD INSECURITY AMONG OLDER ADULTS: A TRANSPROFESSIONAL, COMMUNITY-BASED COLLABORATION

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To address inequities related to food insecurity among older adults, a better understanding of the phenomenon was needed. An innovative screening tool to distinguish among high, medium and low risk and that considers cultural preferences related to food acquisition and related behaviors was developed and piloted. Screenings and healthy eating education were offered at health fairs and other community events. Information about food insecurity and healthy eating as well as resources, such as food maps, guidelines, and food preparation materials were disseminated. Preliminary findings suggest that over half of those screened have high levels of food insecurity. Approximately 37% have five or more comorbidities that combined with food insecurity, represent a significant threat to health and well-being. Elected officials and community leaders soon learned about this initiative and sought education and screening for their constituencies. The research and project evaluation will be used in collaboration with these leaders to identify polices at the local, state and federal level to promote health equity and reduce food insecurity disparities. Efforts are under development to integrate the new screening and referral mechanisms in community-based primary care practices.