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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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