ratio (aOR=1.48, 95% confidence interval (CI): 1.10, 1.98; and living with non-spousal others versus alone, aOR=1.48; 95% CI: 1.09, 2.03), whereas indicators of functional abilities did not. To ensure quality housing for all community-dwelling older adults, efforts that increase financial resources and further examine the role of social environment in deficient housing are needed.

NEIGHBORHOOD ENVIRONMENT AND CARDIOMETABOLIC DISEASE IN INDIVIDUALS AGING WITH PHYSICAL DISABILITY

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The environment may be particularly important for facilitating participation and health for individuals aging with physical disability. However, little is known about which features of the neighborhood are particularly pertinent for this population. This study aims to address this gap by examining the type(s) of neighborhood environments associated with cardiometabolic disease. We identified 26,000 individuals with a diagnosis of physical disability using a national private health insurance claims database in the U.S. Geocoded information for individuals was used to assign them to features of their neighborhood from the National Neighborhood Data Archive. An adapted typology was used to classify neighborhoods into the following based on density of health-promoting and harming features: 1) High health-promoting/harming (service-dense), 2) High health-promoting/low harming, 3) Low health-promoting/high harming, 4) Low health-promoting/harming, and 5) Average. We used time-varying Cox models to estimate adjusted hazard ratios (HR) and 95% confidence intervals (CI) for time-to incident cardiometabolic conditions. High neighborhood-level aflou, and low disadvantage scores characterized service-dense neighborhoods. They had more than 2x higher density of health-promoting resources (e.g., transit) compared to other neighborhood types. Individuals residing in service-dense neighborhoods had an 8% lower risk of any cardiometabolic disease (HR 0.92, 95% CI: 0.85-0.99) compared to those in average neighborhoods. Similar effects were observed for Hypertension and Type 2 Diabetes, with effects most pronounced for the latter (HR 0.82, 95% CI: 0.71-0.94). For individuals aging with physical disabilities, service-dense neighborhoods may be protective against cardiometabolic morbidity. Findings can inform community design that support cardiometabolic health in this population.

NEIGHBORHOOD ENVIRONMENT AND SOCIAL SUPPORT RECEIVED: AN EXAMINATION OF RACE AND GENDER IN BALTIMORE CITY

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Social support in urban settings is likely shaped by the context of the neighborhood environment. Patterns of support may also differ by the type of support received as well as characteristics of the person receiving support. For example, women and Black residents may have stronger support networks compared to men and white individuals, and variation by gender and race in social support may have important implications for promoting well-being in disadvantaged neighborhoods. To investigate the presence of these potential patterns in a disadvantaged urban environment, we analyzed 2,553 Baltimore City residents (ages 30-64) from the baseline wave (2004-2009) of the Healthy Aging in Neighborhoods of Diversity across the Life Span (HANDLS) study. We tested associations between self-assessed neighborhood environment (disorder, cohesion, and control) and social support (from partners, children, and/or friends) and further explored variation by intersections of race and gender using multi-group structural equation modeling. Our results suggest that individuals are more likely to receive support when they perceive their neighborhood to have higher social control and cohesion, particularly in terms of support from friends. Although interactions by race and sex were not statistically significant, a descriptive pattern emerged wherein Black women are particularly likely to receive support from multiple sources when they report more social control in their neighborhood. On the other hand, there is almost no association between neighborhood environment and social support for Black men. We discuss these findings in light of potential neighborhood inequities in informal support access in Baltimore City and similar urban settings.

RESIDENCE IN HUD HOUSING ASSOCIATED WITH GREATER BENEFIT FROM HCBS SERVICES FOR MEDICAID ENROLLLEES IN PENNSYLVANIA

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State Medicaid programs seek to shift the delivery of long-term care services away from institutional settings and toward community-based settings by expanding access to home-and-community-based services (HCBS). HCBS are hypothesized to prevent or delay the need for protracted nursing home stays. This study explores the question of which types of community residence maximize this protective effect of HCBS. We used a probabilistic matching technique to identify whether waiver-eligible Medicaid enrollees were likely to reside in project-based HUD housing in 2013. We applied multinomial logistic regression to observe the risk of long-stay nursing home admission (>100 days) relative to persistent community residence in the subsequent four years. Our model controlled for age, race, gender, urban status, and receipt of home-and-community based services. Our predictor of interest was the interaction between receipt of home and community based services (HCBS) and residence...
in HUD housing. The eligible baseline population included 152,632 community-residing Pennsylvania Medicaid enrollees in 2013. The analytic sample excluded individuals who died during 2013 or who were no longer waiver-eligible after 2013. Residence in HUD project-based housing while receiving HCBS is independently associated with a 27% percent reduction in risk of long-stay nursing home admission (p = .01) when controlling for individual-level demographics. No significant association was observed between the predictor of interest and risk of death during the follow-up period, suggesting that this finding is not likely confounded by individual health status. Further research should test whether this association is causal and specify possible mechanisms.

THE INTERSECTION OF DEMENTIA-FRIENDLY INITIATIVES AND AGE-FRIENDLY ENVIRONMENTS: THE INTEGRATION MODELS

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While age friendly city (AFC) initiatives aim to build supportive physical and social environments for older adults, dementia-friendly initiatives (DFI) see the critical need of persons living with dementia (PWD) to be included in society. Given the close relationship between advanced age and dementia risk, communities facing challenges of aging and dementia will benefit from the integration of DFI and AFC. This study aims to summarize the differences between AFC and DFI practice and to identify integrative models for DFI and AFC based upon cases in the U.S.A and China. Qualitative interviews with 11 stakeholders from Massachusetts and Michigan of the U.S.A and Beijing and Shanghai in mainland China were recorded via Zoom and transcribed for analyses in order to identify different integration models. A summary of differences and commonalities between AFC and DFI core values, key players, major activities, and outcomes is reported. Four practice models of AFC and DFI based upon case analyses were described as sequential integration, concurrent integration, sequential separation, and concurrent separation. Massachusetts’ model is unique in the support from the state government to integrate both from the beginning, and Michigan witnessed separate efforts between grassroots-based agencies and the state government. Shanghai model represents a sequential integration that includes DFI in local government’s long-term aging policy plan, while AFC and DFI in Beijing have a loose connection despite progress made for each initiative. Communities need to develop a practice model considering its local community needs, policy support, and sustainable resources available.

Session 4185 (Symposium)

CARE IN CONTEXT: DEMENTIA SUPPORT IN MEXICO AND THE UNITED STATES
Chair: Sunshine Rote Co-Chair: Jacqueline Angel
Discussant: William Vega

Due to rapid demographic transitions, the number of people with dementia is rising in the Americas, and is expected to double in the coming decades, increasing from 14.8 million in 2030 to over 27 million by 2050. The burden of dementia is especially pronounced for the Mexican-origin population in Mexico and the U.S. For Mexico, financial support for older low-income citizens and medical care are universal rights, but limited fiscal resources and the needs of a large low-income population create inevitable competition for limited resources among the old and the young. Although the United States has a more developed economy and well-developed Social Security and health care financing systems for older adults, Mexican-origin individuals in the U.S. do not necessarily benefit fully from these programs. The institutional and financial problems are compounded in both countries by longer life spans, smaller families, as well as changing gender roles and cultural norms. Such changes affect the Mexican-origin population in particular because of a higher prevalence rates of cognitive impairment than other racial and ethnic groups, and the lower access to resources to provide care. In this GSA Symposium, the authors of four papers deal with the following topics as they relate to dementia care in Mexico and the United States: (1) living alone in late life; (2) living arrangements and dementia care; (3) the role of non-governmental organizations in care; (4) next steps to address dementia care needs in the U.S. and Mexico.

WHEN STRANGERS BECOME FAMILY: THE ROLE OF CIVIL SOCIETY ORGANIZATIONS IN THE CARE OF OLDER PEOPLE

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As in other nations, the aging of the population of Mexico presents many challenges specially in dependence. These social and political changes occur in the context of a series of interacting political, social and demographic transformations. At the end of the 20th and beginning of the 21st centuries civil society organizations have begun to define a third sector. A growing desire of individuals to exercise more direct democracy, has accompanied the growth of identity politics and the rise of groups representing women, indigenous populations, racial and religious minorities, environmental interests, older persons, and others. These groups have changed public discourse and today give individuals greater capacity to demand their basic human and social rights. This paper reviews the impact of these changes on older people and multidimensional care.

DEMENTIA AND LIVING ARRANGEMENTS AMONG MEXICANS AND MEXICAN AMERICANS

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