INFLUENCE OF LABOR MARKET DISPARITIES ON SEX AND GENDER INEQUALITIES IN COGNITIVE DECLINE

State-level labor market disparities have been linked to health outcomes. The current study examines how labor market disparities may shape different patterns of sex/gender inequalities in cognition across race/ethnicity, place, and time. We leverage cognitive outcome data from multiple cohort and nationally representative longitudinal studies, as well as historical data on labor force participation and occupational status from IPUMS CPS. Multilevel modeling analyses was used to examine heterogeneity in sex/gender inequalities in cognitive trajectories within and between race/ethnicity and U.S. state of birth and determine whether such variability is explained by a state-level labor market opportunity composite. We expect women to demonstrate an advantage over men on cognitive measures. Women’s advantage will be more pronounced in states with a small sex/gender gap in labor market opportunities and less pronounced in states with a large gap. The magnitude of this advantage will be greater for White women compared with Black women.

HOUSING STRUCTURE AND OLDER PERSONS
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This research explores the life circumstances of older persons (aged 60 years and above), focusing on the sociodemographic and socioeconomic conditions of those who live alone. We situate the living arrangements of older persons within the global context of changing household structures in 76 countries from all regions of the world. Older persons who live alone are among those most likely to need governmental and other forms of social support. The analysis presented here is crucial for supporting policy responses to the needs of older persons, including the special attention they require during the current COVID-19 crisis. It also supports the operationalization of the Madrid International Plan of Action on Ageing (MIPAA)(United Nations, 2002), the realization of United Nations Principles for Older Persons (United Nations, 1991), and the broader framework of the Programme of Action of the International Conference on Population and Development(ICPA-POA).

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LOCAL, STATE, AND FEDERAL POLICIES
COMMUNITY OPTIONS TO FUND AGING SERVICES: A NATIONAL STUDY TO TRACK LOCAL INITIATIVES
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The majority of federal support for older people needing in-home services and supports comes from the Medicaid program. However, less than 10% of older people are eligible for Medicaid and to receive long-term services, a person must have a severe disability. Many older people with moderate levels of disability or those who are not impoverished are not eligible. In response to these system limitations, some counties across the nation have developed alternative funding strategies, such as property tax levies, to better serve older members of their communities. After identifying 15 states with such initiatives, a survey was distributed to 414 contacts within these states, with a response rate of 55%. Respondents included organizations such as area agencies on aging, councils on aging, and county departments on aging. Local funding varied within and across states, with annual funding ranging from $8,000-$47 million. Most commonly provided services with local funds include home-delivered (81%) and congregate (73%) meals, transportation (61%), and homemaker services (49%). A majority of programs (63%) indicated that local funds are used to provide at least one family or friend caregiver service. This study is the first compilation and description of locally-funded elder service initiatives in the U.S. Locally-funded initiatives can help older people with long-term services needs continue to live in their own homes and communities. On the other hand, some have raised questions about whether this is a good approach to funding aging services, raising concerns that this will lead to further inequities across states and communities.
comparative method of analysis to identify 5 factors that characterized partnerships in the highly-partnered, low-utilization sites: 1) Regional context (e.g., breadth of health care provider market, cross-sectoral coalitions), 2) AAA human resource assets (e.g., community expertise, business acumen), 3) AAA organizational culture (e.g., visionary leadership, risk taking), 4) Interdependence among organizations (e.g., mutual benefit, alignment), and 5) Interpersonal dynamics (e.g., trust, relationships). The importance of these regional, organizational, and relational factors suggests that AAA business acumen is necessary but not sufficient to build and sustain robust cross-sectoral partnerships.

FEDERAL INTERVENTIONS TARGETING SOCIAL ISOLATION AND LONELINESS: AN EXPLORATORY REVIEW

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Even prior to the COVID-19 Public Health and Medical Emergency, the experiences of chronic social isolation and loneliness (SIL) were growing among older adults. Countries began increasing national visibility for these issues and implementing programs and services focused on addressing them. In the United States (US), however, little is known about successful national interventions or their effectiveness in tackling SIL among older Americans. We conducted a rapid review of the peer-reviewed and grey literature from 2009-2019, focusing on existing federal programs, health systems, and health care models in the US that address SIL among older adults. Of the 110 articles identified, 36 met the inclusion criteria and were synthesized. Our review found few federal interventions that directly address SIL; several may be addressing SIL as an auxiliary outcome to addressing social determinants of health, such as group exercise, transportation support, or food insecurity. While these interventions may provide a promising opportunity, implementation and evaluation challenges were identified. Thus, federal and state agencies face significant obstacles to understanding the impact of existing interventions and their effectiveness in addressing SIL, hampering progress toward large scale implementation. As SIL receives increasing attention, we add another voice to existing literature that indicates significant heterogeneity among existing programs; we found that few evidence-based, scalable federal initiatives exist in the US that target SIL. Without resources from federal and state agencies, the ability of health entities, community-based organizations, and direct care providers to implement effective interventions is significantly diminished.

THE EFFECT OF INCREASING STATE MINIMUM WAGE ON FAMILY CAREGIVING

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Paid long-term care workers, such as personal care aides, compliment family caregivers in the delivery of care for people with long-term care needs. Nearly 12% of paid long-term care workers live in poverty. There is a call to raise the federal minimum wage from $7.25/hr to $15/hr. Long-term care workers may financially benefit from an increase in minimum wage, but families that rely on paid long-term care may be unable to afford higher wages. We obtained Health and Retirement Study (HRS; 2006-2014) respondents’ state of residence which we linked with state minimum wage data. Between 2006 and 2010 the federal minimum wage increased from $5.15 to $7.25. We identified 25 states in which the 2006 to 2010 (pre period) increases in federal minimum wage increased the state's effective minimum wage (higher of state and federal minimum wage). Seven of these states continued to increase their minimum wage from 2010 to 2014 (post period). The remaining 18 matching control states did not increase their minimum wage after 2010. We used a difference-in-differences design and ordinary least squares regression to compare hours of unpaid and paid caregiving HRS respondents received in treatment and control. There was no statistically significant change in unpaid (-2.15; 95%CI: -8.53, 4.23) or paid (2.42; 95%CI: -1.33, 6.20) caregiving hours received between HRS respondents that lived in states that did and did not increase their minimum wage. Increasing state minimum wage may improve the economic wellbeing of long-term care workers without adversely affecting people with long-term care needs.

THE EFFECT OF MEDICAID ENROLLMENT ON FAMILY CAREGIVING

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Most people with long-term care needs rely on family caregivers. People with long-term care needs are also more likely to be eligible for Medicaid, which is the largest public payer of home and community based long-term care services. Whether enrolling in Medicaid compliments or substitutes for family caregiving is unknown. We linked Health and Retirement Study (HRS) respondents with their Medicaid enrollment data (2002-2012), to determine the effect of enrolling in Medicaid on family caregiving hours. We identified 130 people that participated in the HRS interview prior to enrolling in Medicaid in the same year (i.e., untreated) and 142 people that participated in the HRS interview after recently enrolling in Medicaid (i.e., treated). Untreated and treated respondents had similar demographic characteristics (age, sex, race). We estimated a series of inverse probability weighted linear regression adjusted models to determine the difference in monthly family caregiving hours between individuals that newly enrolled in Medicaid compared to people that had yet to enroll. We controlled for HRS respondents’ demographics, health care utilization, and nursing home utilization. HRS respondents interviewed after enrolling in Medicaid received 5.98 (95%CI: -27.60, 39.57) fewer monthly hours of family caregiving than respondents that had yet to enroll in Medicaid. HRS respondents