sampling to recruit English/Spanish-speaking, cognitively intact, community-dwelling older adults (age ≥ 60) across New York State, this study conducted computer assisted telephone interviews (CATI) with 628 respondents participating in both Wave 1 and Wave 2 interviews (response rate=60.7%). Ten-year EM incidence was regressed on factors related to physical vulnerability, living arrangement, and socio-cultural characteristics using logistic regression. Ten-year incidence rates included overall EM (11.4%), financial abuse (8.5%), emotional abuse (4.1%), physical abuse (2.3%), and neglect (1.0%). Poor self-rated health at Wave 1 significantly predicted increased risk of new Wave 2 overall EM (odds ratio [OR]=2.8), emotional abuse (OR=3.67), physical abuse (OR=4.21), and financial abuse (OR=2.8). Black older adults were at significantly heightened risk of overall EM (OR=2.61), specifically financial abuse (OR=2.8). Change from co-residence (Wave 1) toward living alone (Wave 2) significantly predicted financial abuse (OR=2.74). Healthcare visits represent important opportunities to detect at-risk older adults. Race is highlighted as an important social determinant for EM requiring urgent attention. This study represents the first longitudinal, population-based EM incidence study.

PERCEIVED FINANCIAL VULNERABILITY IS RELATED TO PERCEIVED COGNITIVE IMPAIRMENT AND LIVING ALONE

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Objective: Perceived financial vulnerability is linked to physical and mental health and also to risk for financial exploitation (Lichtenberg et al., 2020a,b). This study examined the relationship of risk scores for financial exploitation to demographic variables, perceived memory loss and living alone. Methods: The 17-item self-report Financial Exploitation Vulnerability Scale (FEVS) posted on our website https://olderadultnestegg.com was completed by a convenience sample of 258 older adults. Correlational, multiple regression and Chi Square analyses were used. Results: Thirty percent of the sample scored at an elevated risk for financial exploitation due to perceived financial vulnerability. Although this was a convenience sample the results were similar to what was found in a sub-study of the HRS. Thirty eight percent of participants were living alone and 38% reported that their memory was less reliable than a year ago. Financial vulnerability risk score was significantly related to decreased education (r=-.12), living alone (r=.21) and perceived memory loss (r=.35). Eighteen percent of the variance was accounted for in a multiple regression (F(5,250)=10.73, p<.001, r2=0.18) with all three measures predicting FEVS risk score independently. The combination of perceived memory loss and living alone was significantly associated with the highest percentage of elevated risk scores. Discussion: Perceived financial vulnerability and its relationship to health (e.g. memory loss) and financial exploitation, continues to be under-appreciated in gerontology and geriatrics research. Our findings, consistent with GSA’s Longevity Fitness report further highlights this important dimension.

RISK FACTORS OF FINANCIAL EXPLOITATION VERSUS SCAM

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Financial exploitation (FE) perpetrators are usually seen in a position of trust, such as family members or friends, whereas perpetrators of scam tend to be unknown individuals. Few empirical studies have examined victim risk factors, and this study aimed to systematically compare risk factors of FE versus scam. One-hundred-and-ninety-five adults (ages 18-89) were recruited to complete a 60-minute survey and interview at Purdue University in Indiana (n=97) and Scripps College in California (n=98). Risk factors assessed included cognitive tasks (overall cognition, memory, and executive decision), socio-emotional questionnaires (depression, resilience, ostracism, and social integration), financial measures (numeracy, objective financial knowledge, retirement worries, and financial well-being), physical health and demographics (age, gender, education level, marital status, ethnicity). Additionally, participants reported experiences of FE and scam, including (1) the 11-item short-form Older Adult Financial Exploitation Measure, (2) seven questions on scam from the Health and Retirement Study, and (3) likelihood to contact a scammer after reviewing lottery scam materials. The three dependent variables were log-transformed before OLS regression models were built. Each dependent variable was associated with different risk factors. Lower standard of living (p<.02) and ostracism (p<.05) independently predicted FE. Lower physical health (b=-.02, p=.003) was the strongest predictor of scam, with lower level of financial well-being (p<.02) serving as an independent predictor. For lottery scams contact likelihood, ostracism (b=.04, p=.003) and being male (b=-.23, p=.04) were the strongest predictors. Since risk factors differed between FE and scam, prevention and intervention programs should target the unique profiles of risk factors for each.

STRUCTURAL AND INDIVIDUAL AGEISM PREDICTS ELDER ABUSE PROCLIVITY AND PERPETRATION

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Considering that elder abuse affects one in six older persons worldwide, a need exists to identify factors that predict this abuse. Previous studies have found that ageism operates at both structural (i.e., societal-level stigmatizing views toward older persons) and individual levels (i.e., negative age beliefs) to affect health. However, it was not known whether and if so, how these two levels
work together to impact perpetrators committing elder abuse. Thus, examining the mechanism between ageism and elder abuse was the aim of the current study. We hypothesized that structural and individual ageism would simultaneously predict elder abuse. In addition, following Stereotype Embodiment Theory, the impact of structural ageism on elder abuse would be mediated by individual ageism. In Sample 1, participants described their proclivity to abuse older people if they could do so without punishment (n=1,580). In Sample 2, family caregivers described actual abuse of their older care recipients (n=400). Overall, elder abuse proclivity (33% in Sample 1) and perpetration (56% in Sample 2) were prevalent. As hypothesized, structural ageism and individual ageism simultaneously predicted elder abuse proclivity and perpetration. Also as predicted, individual ageism significantly mediated the association between structural ageism and elder abuse in both samples. This the first study that examined the mechanistic pathways between structural and individual levels of ageism in the context of elder abuse. Effective solutions to prevent elder abuse should incorporate upstream interventions to mitigate the adverse effects of ageism.

Session 1340 (Symposium)

POLICY SERIES: BUILDING MOMENTUM FOR DIVERSITY, EQUITY, AND INCLUSION IN GERIATRICS AND GERONTOLOGY EDUCATION

Chair: Jennifer Severance
Co-Chair: Barbara Gordon
Discussant: Brian Lindberg

With an increasingly multicultural and diverse older adult population, health care professionals must be prepared to serve older adults from varied backgrounds and marginalized communities; address health determinants and disparities; and promote diversity, equity, inclusion, and empathy within systems of care. The National Association for Geriatrics Education (NAGE) is a non-profit organization representing geriatric and gerontology education and training programs, including Health Services and Resource Administration funded Geriatric Workforce Enhancement Programs (GWEPs), and Geriatric Academic Career Awardees (GACAs). NAGE responded to the renewed call to address systemic racism and racial inequities by forming a Diversity and Racial Equity Workgroup. The Workgroup explored ways to disseminate educational resources, support members to address racial inequities among older adults, promote increased diversity of the geriatrics/gerontology workforce, and support public policy initiatives that address racism and health disparities. Initial outputs include creating a Diversity and Racial Equity resource page, identifying liaisons to the Workgroup from each NAGE Committee to ensure impact across the organization, and organizing collaborations across GWEPs and GACAs to share successful initiatives. Future plans include education and advocacy with members and collaborating organizations to address systemic racism and racial health inequities impacting older adults.

REFLECTION LEADING TO ACTION ON DIVERSITY, EQUITY, AND INCLUSION AT THE VIRGINIA GWEP

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Last year’s Black Lives Matter protests inspired the Virginia Geriatric Education Center (VGEC) GWEP’s plenary to engage in reflection and discussion on diversity, equity, and inclusion (DEI) in our work together. During each bi-monthly meeting, we dedicate time to generate ideas to improve our programming, how we work together, and how we partner and recruit for our programs. Champions for DEI on our plenary led an effort to develop a DEI newsletter clarifying DEI concepts and introducing resources thematically related to the monthly VGEC faculty development program curriculum. By incorporating these resources into our monthly curriculum, facilitators have a new access point to incorporate content on health equity and policy into our curriculum. The intentional focus on DEI is opening the door to context. Presenters discuss strategies and opportunities to disrupt and transform health professions education at multiple levels and implications for policies supporting optimal aging for all older adults.

ANSWERING THE CALL FOR DIVERSITY AND RACIAL EQUITY: THE NATIONAL ASSOCIATION FOR GERIATRIC EDUCATION

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