that support many of the key concepts of Age-Friendliness (i.e. social participation, respect and social inclusion, civic engagement, transportation, and community supports and health services). Senior centers are the front line of aging services and thus in a position to implement programs and raise public awareness about age-friendly initiatives. The purpose of this presentation is to present and discuss the involvement of senior centers or other senior service agencies, as well as to characterize the mobilization of a community after joining the movement. We will present 5 case studies of age-friendly communities who are in the implementation phase of their initiative, to illustrate the challenges, opportunities, and outcomes associated with placing a senior center at the forefront of the movement. Based on the results of this work, we will present a typology of age-friendly community initiatives as a mechanism for supporting other communities make this transition. We conclude with a discussion of how age-friendly communities are part of the paradigm shift of aging in community and the ways in which this work intersects with other health policy initiatives with which cities and towns engage.

SESSION 2814 (PAPER)

SOCIAL ISOLATION AND SOCIAL SUPPORT

DEPRESSIVE SYMPTOMS AND LONELINESS AMONG BLACK AND WHITE OLDER ADULTS: THE MODERATING EFFECTS OF RACE

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Loneliness is consistently linked to worse depression/depressive symptoms; however, few studies examined if this relationship varies by race. The purpose of this study was to determine if race moderated the relationship between loneliness and depressive symptoms among a nationally representative sample of older Black and White adults. Data come from the 2014 wave of the Health and Retirement Study (HRS) Core survey and Psychosocial Leave Behind Questionnaire; only Black and White older adults were included in the analysis (N=6,469). Depressive symptoms were operationalized by the CESD; however, the ‘felt lonely’ item was removed given concerns with collinearity. Loneliness was operationalized using the Hughes 3-Item Loneliness Scale. Sociodemographic variables included gender, age, education, household income, employment status, marital status, and living alone or with others. Furthermore, social support and negative interactions from family members and friends, and religious service attendance were included in the analysis. Lastly, we created an interaction term with race and loneliness. All analyses used survey weights to account for the complex multistage sampling design of the HRS. Missing data were multiply imputed. Older Blacks had higher rates of loneliness and depressive symptoms compared to older Whites. In multivariate analysis, we found race significantly moderated the relationship between loneliness and depressive symptoms while controlling for sociodemographic, social support, negative interaction, and religious attendance covariates. For both older Blacks and Whites, greater loneliness affected depressive symptoms; however, the effect was stronger among Whites than it was for Blacks. Findings can be used to create racially sensitive depression interventions.

GEOGRAPHIC DISTANCE AND SOCIAL ISOLATION AMONG FAMILY CAREGIVERS PROVIDING CARE TO OLDER ADULTS

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Family caregiving is associated with social isolation, but the role of geographic distance between caregiver and receiver in caregiving experience is unclear with mixed research findings. This study examined the relationship between geographic distance and caregiver social isolation (CSI), and explored the interaction between geographic distance and caregiving intensity in association with CSI. Based on the Ecological Model of Caregiver Isolation, hierarchical linear regression and ANCOVA analyses were applied to conduct data analysis with the 2012 Canadian General Social Survey (N=2,881). Caregivers living a short distance from receivers reported the lowest CSI than coresident, moderate and long distance caregivers. Being involved in higher intensity caregiving as the primary caregiver, undertaking more caregiving tasks, and providing care more frequently resulted in higher CSI scores. Additionally, long and moderate distance caregivers reported greater CSI than coresident and short distance caregivers only when providing higher intensity caregiving. Geographic distance is a salient contextual factor affecting CSI, and longer distance creates environmental barriers for caregiving provision. Employing a granulated measure of geographic distance positioned within an ecological framework facilitates an understanding of the nuanced association between geographic proximity and CSI. Furthermore, the identified interactive effects between geographic distance and caregiving intensity on CSI further reveal the complexity of caregiving experience. The findings are relevant for programs supporting caregivers in different contexts, especially physical distance.

HOW LONELINESS, DEPRESSED MOOD, AND DIET AFFECT EATING HABITS AND GROCERY SHOPPING

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This study examined the prevalence of loneliness and relationship with cooking and eating habits among older adults using data collected in December 2019 from a nationally representative sample age 50-80 through the National Poll on Healthy Aging. Older adults who live alone were more likely those who lived with others (19% vs. 8%) and those with a high PHQ-2 score were more like than those with a low PHQ-2 score (20% vs. 11%) to report that they do not cook dinner most days (0-2 times/week). Those who rated their diet as fair/poor were more likely to indicate they cook few meals a week (0-2) compared to those who reported a good or very good/excellent diet (18% vs. 11 % vs 8%).
Those with a high PHQ-2 score were less likely than those with a low PHQ-2 score to say they do major food shopping less than once a week (31% vs 47%). Those with a high PHQ-2 score were more likely to say that that always ate alone in the last week compared to those with a low PHQ-2 score (17% vs 7%). These findings demonstrate that older adults who lived alone, had a higher PHQ-2 score, and had a poorer diet were more likely to cook and do grocery shopping less often. Strategies and policies to support older adults to address depressive symptoms and to increase cooking and improve diet may have many health and social benefits and will be explored through this session.

I AM NOT INVISIBLE: THE IMPACT OF AGE DISCRIMINATION IN THE WORKPLACE

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Ageism and age stereotypes are widespread. They shape the lived experiences of older workers. This presentation focuses on the results of responses to an online survey exploring the impact of ageist treatment in the workplace. The results of online surveys from 113 teachers over the age of 50 indicated that ageist treatment is widespread. An analysis of open ended questions addressing the stressful impact of being victimized by ageism indicated that feeling invisible, isolated, and helpless are the three most common responses to ageist treatment in the workplace. Being victimized by ageism presents a threat to older workers sense of self and feelings of competence. The cultivation hypothesis suggests that in technologically advanced societies such as the United States, people often rely on the media as a primary source of cultural information. Media images tend to depict older adults in ways that maintain and create ageist stereotypes. Our research suggests that the framing of media content significantly influences the self-worth of older workers. In this presentation, we discuss examples of ageism in the workplace, the family, and the media, and discuss ways of combating biased and discriminatory treatment. Based on our ongoing research, we make suggestions for ways of responding to and coping with ageist treatment.

MEASURING CHILDLESSNESS AMONG MIDDLE-AGED AND OLDER AMERICANS

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Existing literature on childlessness among middle-aged and older Americans is sparse, and measuring childlessness is not straightforward for those with complex family histories. To address this knowledge gap, we examined data on 19,929 respondents age ≥50 from the 2016 Health and Retirement Study. All analyses accounted for complex sample design to generate nationally representative estimates. The proportion of respondents without children differed significantly depending on how “childless” was defined: 1) 14.9% (95% confidence interval [CI]: 13.9-15.9%) having no biological children, versus 2) 10.4% (95% CI: 9.5-11.3%) having no children/step-children that were living and in-contact. When measured based on absence of biological children, the prevalence of childlessness was higher in younger cohorts (17.7%, 13.2%, and 9.0% for age 50-64, 65-74, and ≥75 years, respectively, p<0.001) and among more educated individuals (17.4%, 12.3%, and 9.6% for more than high school, high school, and less than high school education, respectively, p<0.001). The prevalence of childlessness was also higher among men (16.7%) than women (13.2%) (p<0.001) and among non-Hispanic whites (16.0%) than Hispanics (9.8%) (p<0.001). Similar patterns, but lower prevalence, were observed when measuring childlessness based on absence of children/step-children that were living and in-contact. Although non-Hispanic whites (16.0%) were more likely than non-Hispanic blacks (13.0%) to have no biological children (p=0.007), a similar proportion of them had no children/step-children that were living and in-contact (10.8% versus 10.6%, p=0.06). Given fertility decline and growing family complexity, these findings help inform the structure of social support and long-term care needs of middle-aged and older Americans.

SESSION 2817 (PAPER)

INFORMAL AND FORMAL CAREGIVING ISSUES

CAREGIVER MENTAL HEALTH OUTCOMES: ARE THERE DIFFERENCES ACROSS GENERATIONS?

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Informal caregivers are a critical component of support for the rapidly aging population. Previous studies have addressed the effects of caregiving on mental health. However, they have not focused on differences among generational cohorts of caregivers of older adults, i.e., Millennial (born 1981-1996), Generation X (born 1965-1980), Baby Boomer (born 1946-1964), and Silent Generation (born 1928-1945). As the Millennial caregiver population grows in parallel with older adults and their increased needs, we must better understand Millennial responses to caregiving. Millennial caregivers have an incidence rate ratio of 1.22 compared to Generation X caregivers (p<0.001). Millennial caregivers provide a similar intensity of care as Baby Boomers in terms of hours per week but are more likely to be fully employed (40+ hours per week or more). We used caregiver data from the nationally representative Centers for Disease Control’s Behavioral Risk Factor Surveillance System (BRFSS) survey from 2015-2017 to conduct negative binomial regression (n=50,745). Data analysis indicates that Millennial caregivers have an incidence rate ratio of 1.22 times more self-reported days of “stress, depression, and/or problems with emotions” compared to Generation X caregivers (p<0.01); 1.64 times compared to Baby Boomers (p<0.001); and 2.38 times compared to Silent Generation caregivers (p<0.001). Generational differences show that Millennial caregivers may have different needs than older