(OR=.61, 95% CI=0.45,0.83). In multi-group analyses, levels of cannabis use effects on SCD remained statistically significant in the 45-64 age group, but not in the 65+ group. Further research targeting SCD is needed to design interventions particularly for middle-age cannabis users whose health has been compromised by disease or age-related vulnerabilities and are at greater risk for adverse cognitive outcomes from cannabis use.

CLINICAL RECOMMENDATIONS FOR REDUCING THE RISK OF COGNITIVE DECLINE
G. Adriana Perez,1 Kelly O’Brien,2 Marwan Sabbagh,1 and Michelle Bruno,1 1. University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania, United States, 2. UsAgainstAlzheimer’s, Chicago, Illinois, United States, 3. Cleveland Clinic Nevada, Las Vegas, Nevada, United States, 4. Avalere Health, Washington, District of Columbia, United States

As much as 40% of dementia cases can be attributed to modifiable risk factors (Livingston et al., 2020). Much of that risk-reduction can be accomplished by changing behavior in midlife. In light of the emerging evidence that dementia may be preventable, UsAgainstAlzheimer’s convened a workshop of national experts to develop new recommendations that primary care physicians and general neurologists can use to initiate primary prevention conversations with their patients about cognitive decline. Few resources address steps that clinicians can take in their routine care to help patients reduce risk. Some relevant resources provide excellent guidance but tend to be more focused on early detection or slowing disease progression rather than primary prevention. The Risk Reduction Workgroup (RRWG) was convened to help address the need for clinicians to know how to discuss cognitive decline with their patients. The workgroup aligned on 11 recommendations for primary care physicians and general neurologists. In addition the RRWG provide considerations for implementing the recommendations in clinical practice. The recommendations are mindful of social determinants of health, account for cultural differences, and are designed for general accessibility. This effort is part of a broader initiative by UsAgainstAlzheimer’s to address risk-reduction for cognitive decline and early interventions. Under the guidance of a multidisciplinary Provider Leadership Group consisting of representatives from some of the nation’s largest health provider serving organizations, three independent workgroups are developing guidance and tools to assist providers in their clinical practice and improve health outcomes for patients at-risk for Alzheimer’s and related dementias.

PATIENT COGNITIVE IMPAIRMENT ASSOCIATED WITH GREATER CARE INTENSITY DURING MEDICARE HOME HEALTH CARE
Julia Burgdorf,1 and Kathy Bowles,2 1. Center for Home Care Policy & Research, New York, New York, United States, 2. University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania, United States

Medicare beneficiaries with cognitive impairment are more likely to access home health care than those without such impairment, and an estimated 1 in 3 Medicare home health patients has diagnosed dementia. However, recent changes to the Medicare home health payment system do not adjust for patients’ cognitive impairment. To the extent that cognitive impairment prompts higher intensity care, this could create a financial disincentive for providers serving this patient population. We draw on a nationally representative sample of 1,214 (weighted n=5,856,333) community-living Medicare beneficiaries who received home health care between 2011-2016. We measure care intensity by the number and type of visits received during an index home health care episode. We model care intensity as a function of patient cognitive impairment during the episode, measured via clinician reports in standardized patient assessment data. In propensity score adjusted, multivariable models holding all covariates at their means, home health patients with identified cognitive impairment received a significantly greater number of visits. During the index home health episode, cognitively impaired patients received an additional 2.82 total visits (95% CI: 1.32-4.31; p<0.001), 1.39 nursing visits (95% CI: 0.49-2.29; p=0.003), 0.72 physical therapy visits (95% CI: 0.06-1.39; p=0.03), and 0.60 occupational therapy visits (95% CI: 0.15-1.05; p=0.01). Findings suggest that recent changes to Medicare home health care reimbursement do not reflect the more intensive care needs of patients with cognitive impairment, and may threaten access to care for these individuals.

RISK FACTORS FOR COGNITIVE DECLINE IN OLDER ADULTS IN PUERTO RICO: ASSESSING BIAS FROM SAMPLE ATTRITION
Brian Downer,1 Caitlin Pope,2 Tyler Bell,3 Sadaf Milani,1 Ross Andel,4 and Michael Crowe,4 1. University of Texas Medical Branch, Galveston, Texas, United States, 2. University of Kentucky, Lexington, Kentucky, United States, 3. University of California San Diego, La Jolla, California, United States, 4. University of South Florida, Tampa, Florida, United States, 5. University of Alabama at Birmingham, Birmingham, Alabama, United States

Many risk factors for cognitive decline are associated with mortality and are common among older adults who cannot complete a survey interview. Our objective was to compare analyses of risk factors for cognitive decline among older adults in Puerto Rico with and without accounting for sample attrition. Data came from the Puerto Rican Elderly: Health Conditions Study. Our sample included 3,437 participants interviewed in 2002/03. Cognitive function was measured using the Mini-Mental Caban (MMC). The outcome was the change in MMC score between 2002/03 and 2006/07. Logistic regression was used to estimate inverse probability weights for being interviewed in 2006/07 (n=3,028) and completing the MMC at follow-up (n=2,601). Linear regression models were used to assess the association between stroke, hypertension, diabetes, smoking status, and cognitive decline with and without the IPWs. In the unweighted analysis, stroke was associated with a significantly greater decline in cognition (b=-0.62, standard error [SE]=0.30, p=0.04). Hypertension (b=-0.02, SE=0.12, p=0.84), diabetes (b=-0.22, SE=0.13, p=0.10) and being a current (b=0.05, SE=0.22, p=0.84) or former smoker (b=0.05, SE=0.14, 0.74) were not associated with cognitive decline in the unweighted analysis. The results were similar when including the IPW for mortality (stroke b=-0.63; hypertension b=-0.03; diabetes: b=-0.20; current
smoker: b=0.08; former smoker: b=0.07) and having completed the MMC at follow-up (stroke b=-0.58; hypertension b=-0.03; diabetes: b=-0.20; current smoker: b=0.03; former smoker: b=0.09). These findings indicate that stroke is a risk factor for cognitive decline among older Puerto Rican adults even after accounting for selective attrition.

THE UTILITY OF THE WHO INTRINSIC CAPACITY SCREENING TOOL TO IDENTIFY PHYSICAL AND MENTAL FUNCTION DECLINES
Lina Ma, Yaxin Zhang, Pan Liu, and Yun Li, Xuanwu Hospital, Capital Medical University, National Research Center for Geriatric Medicine, Beijing, Beijing, China (People’s Republic)

Background: The disease concept is increasingly being replaced by a functional approach to address the healthcare needs of the older people. WHO proposed the Integrated Care for Older People (ICOPE) screening tool to identify older people with priority conditions associated with declines in intrinsic capacity (IC). Very few evidence on the clinical utility of the ICOPE tool is available. Objectives: To determine if the tool can identify adults with poor physical and mental function. Method: 376 participants aged 50–97 years were included. IC was assessed with the WHO ICOPE screening tool, covering the following five domains: cognitive decline, limited mobility, malnutrition, sensory loss, and depressive symptoms. We assessed the activities of daily living, the Fried frailty phenotype, FRAIL scale, SARC-F scale, MMSE, GDS, social frailty, and quality of life. Peak expiratory flow, bones mineral density, body composition were obtained. Results: 69.1% of the participants showed declines in IC. Participants with declines in IC were older, had more chronic diseases, worse general health, worse physical function as indicated by lower Barthel index, walk speed, grip strength, and physical fatigue, worse mental function indicated by lower MMSE scores, higher GDS scores, more mental fatigue, and worse social function. After adjusting for age, IC was positively correlated with walking speed, resilience score, and MMSE score and negatively correlated with frailty, SARC-F score, IADL score, GDS score, and physical and mental fatigue. Conclusion: The WHO ICOPE screening tool is useful to identify adults with poor physical and mental function in Chinese older adults.

Session 2205 (Symposium)

COVID VACCINE ROLLOUT FOR OLDER PEOPLE:
EAST MEETS WEST
Chair: Nengliang Yao
Co-Chair: Tom Cornwell
Discussant: Cheryl Camillo

Older adults should be one of the first groups to receive COVID-19 vaccines, because the risk of dying from COVID-19 increases with age. However, it takes time to distribute the vaccines to different countries, and the challenges in administering vaccines may differ by health system characteristics and local culture. This international symposium will discuss the vaccine rollout issues in eight countries (Isreal, Japan, South Korea, China, France, United Kingdom, Canada, and United States). We will use an interview and dialog format, instead of presentations. We will cover extensive topics including: Availability - What vaccines? Access, Acceptance, Caregivers – How are providers responding/handling caregivers wanting to be vaccinated? Cost/Financing Issues, Distribution Logistics/Transport/Safety, Lessons Learned, Mutations/Variants, Partnerships needed to vaccinate homebound patients (community partners; home health agencies, etc.), Who can/should provide vaccination? The situation with COVID-19 is still very fluid. Countries are at different stages of vaccinating older people. The chair didn’t ask the speakers to write an abstract now; instead, the speakers will collect more information during the next few months and plan to have a prep meeting one month before the Annual Meeting.

COVID VACCINE ROLLOUT FOR OLDER ADULTS IN JAPAN
Tadashi Wada, Irahara Primary Care Hospital, Chiba, Chiba, Japan
It has just started in Japan. We will provide detailed information later. The symposium has experts from 8 countries. We will use an interview and dialog format, instead of presentations.

COVID VACCINE ROLLOUT FOR OLDER ADULTS IN SOUTH KOREA
Chan Mi Park, Asan Medical Center, Songpa-gu, Seoul-t’ukpyolsi, Republic of Korea
It has just started in South Korea. We will provide detailed information later. The symposium has experts from 8 countries. We will use an interview and dialog format, instead of presentations.

COVID VACCINE ROLLOUT FOR OLDER ADULTS IN ISRAEL
Naim Mahroum, Sabar Health, Even Yehuda, Tel Aviv, Israel
The COVID vaccine rollout in Israel has prioritized older adults. It led to a substantial decline in the incidence of COVID-19 in older adults. The new variants are threats to the current achievements. We will provide detailed information later. The symposium has experts from 8 countries. We will use an interview and dialog format, instead of presentations.

COVID VACCINE ROLLOUT FOR OLDER ADULTS IN FRANCE
Matthieu De Stampa, Assistance Publique - Hôpitaux de Paris, Paris, Ile-de-France, France
Only about three million people in France have so far received at least one dose of a Covid-19 vaccine. Those aged over 75 are offered either Pfizer or Moderna vaccines in a vaccination center. Older people with pre-existing conditions can now get AstraZeneca’s Covid-19 vaccine. We will provide detailed information later. The symposium has experts from 8 countries. We will use an interview and dialog format, instead of presentations (please refer to the program overview).

COVID VACCINE ROLLOUT FOR OLDER ADULTS IN THE UNITED KINGDOM
Huajie Jin, King’s College London, London, England, United Kingdom
As of early March, at least 22 million adults had received one dose of a Covid vaccine in the UK, with 1.2 million of