and Instrumental Activities of Daily Living (IADLs). Because ADLs and IADLs are integral to the maintenance of physical health, hygiene, and well-being, the unrelieved desire for help with such activities could signal neglect. Accordingly, we assign “high neglect risk” to respondents who report either that they: (a) want but are not getting help with an ADL or IADL; or (b) are getting help with an ADL or IADL, but from a helper who is not very reliable. Motivated by current research that documents higher rates of morbidity and mortality among neglected older adults, we examine associations between neglect risk and other key NSHAP measures, including indicators of physical health, mental health, cognition, social support, social strain, and field interviewer assessed respondent hygiene. Results suggest that this method of risk assessment can be useful in identifying vulnerable populations of older adults. Follow-up interviews are needed to further confirm its utility as a risk assessment tool.

INVESTIGATING ELDER ABUSE AND NEGLECT IN DIVERSE REFUGEE COMMUNITIES IN GREENSBORO, NC
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Elder abuse and neglect (EAN) comprises multiple dimensions, is experienced by about 10% of older adults in the U.S in diverse communities, and is severely detrimental to older adults’ (OA) health and wellbeing. However, documentation of EAN among refugee OA is greatly lacking as are services for these communities. Refugee OA are overall underserved members of marginalized communities. This paper reports on a community-engaged study to collect information and raise awareness of EAN among OA in 2 North Carolina refugee communities - Nepali-speaking Bhutanese and Congolese. Research partners included University researchers and community refugee-serving organizations. Surveys and focus group interviews were conducted. 17 Nepali-speaking Bhutanese and 13 Congolese filled out survey questions, including the Elder Abuse Suspiion Index. They participated in focus group discussions (FGDs), separately for men and women of each community. Survey results indicated EAN more among Congolese than Nepali-speaking Bhutanese. FGD results showed both communities prefer to depend on family members, and experience difficulties with language, transportation, and economic insecurity. No EAN was reported in the FGDs. In line with principles of community-engaged approaches, a capacity-building event to increase awareness of EAN was held, attended by 25 persons from the two communities. This study adds documentation on an under-researched area and marginalized communities. Action recommendations include disseminating culturally appropriate EAN information, strengthening English language and job skills and transportation options, encouraging cooperation across state, nonprofit, educational, and service organizations to address needs of older refugee adults.

OLDER ADULTS AND FAMILY DISCORD OR VIOLENCE DURING THE COVID-19 PANDEMIC: RESULTS OF A CANADA-WIDE SURVEY
Gloria Gutman,1 Brian de Vries,2 Robert Beringer,3 Panee Gill,4 Helena Dault,4 and Moijan Karbakhsh,1, 1. Simon Fraser University, Vancouver, British Columbia, Canada, 2. San Francisco State University, Palm Springs, California, United States, 3. University of Victoria, Victoria, British Columbia, Canada, 4. Simon Fraser University, Surrey, British Columbia, Canada, 5. Victoria Hospice, Victoria, British Columbia, Canada

Child abuse and intimate partner violence rates are known to increase during and in the aftermath of disasters. Research on elder abuse during disasters, including the current pandemic, is limited. As part of an online survey that explored older Canadians’ current experiences and future care plans during the COVID-19 pandemic, we aimed to determine the prevalence, contributing factors and potential outcomes of frequent family discord involving physical violence (FFD/PV) as a proxy for elder abuse. The survey was conducted between Aug 10 and Oct 10, 2021. Respondents (n=4380) were recruited using social media, direct email, Facebook advertising and with the assistance of 85 local community, regional and national organizations. The sub-sample reporting FFD/PV (n=76, 1.8%) was compared with other survey respondents regarding socio-demographic characteristics, negative and positive emotions, difficulty accessing basic needs, food, health care and support. Respondents experiencing FFD/PV were found to be significantly younger and less educated and were more likely to be non-white and not working than other respondents. The subgroup sustaining FFD/PV reported significantly higher rates of feeling depressed, lonely, isolated, anxious, sad, and judged/shamed and felt less happy, relaxed and accepted in their community. They also reported higher rates of challenges in accessing basic material needs such as food, support, medical care, mental health treatment and experienced more changes in life routines. Although only a small percentage reported FFD/PV, our results highlight a disturbing pattern that merits serious attention of adult protection agencies, seniors’ advocates and disaster response organizations.

PREDICTORS OF DEPRESSION IN HEALTHCARE PATIENTS AT RISK OF SELF-NEGLECT
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More than half of reports to Adult Protective Services agencies nationwide involve allegations of self-neglect. An intensive case management intervention for preventing self-neglect was evaluated in a longitudinal study conducted collaboratively by a large healthcare system, Adult Protective Services, and a gerontological research institute. Patients (444) who were older (60+ years) and/or disabled (18+ years) were randomly selected for participation from 19 primary-care clinics if they had risk factors for self-neglect, including depression, substance abuse, dementia, and/or impairment in activities of daily living. Average age was 68 years (SD=12.5), 68% were Hispanic, 68% had monthly income of less than $1,361, and 67% were female. Clinics were randomized into intervention and control groups. Intervention clinic patients received intensive case management services; control clinic patients received usual care, including social work services. Subjects were interviewed at baseline and four months later. The Stress Process Model guided a multiple regression analysis. Domains of background characteristics, primary and
secondary stressors, and support (patients in intervention or control group) were entered in blocks to predict depression levels at post-test. While no significant differences were found in post-test depression levels between intervention and controls, the final model was statistically significant (adjusted R² = .452). Significant predictors of depression were: younger age (disabled adults), poorer self-rated physical and emotional health, greater loneliness, and less social support. Future analyses will examine effects of moderating variables on post-test depression levels. Practice implications of preliminary analyses include addressing disabled adults’ mental health needs, especially if they are isolated and lack social support.

Session 3040 (Symposium)

EXPANDING THE SCOPE OF ADMINISTRATIVE HEALTH RECORDS THROUGH ADVANCED STATISTICAL METHODS
Chair: Igor Akushevich Co-Chair: Carl V. Hill Discussant: Konstantin Arbeev
The objective of the Symposium is to expand familiarity of the application of advanced methods of modern statistical modeling and data management, to administrative health data by combining methodological innovations with practical hands-on demonstrations. Topics will cover a range of methodological and substantive topics including: i) decomposition and partitioning approaches in analysis of disparities and time trends in AD/ADRD; ii) new artificial intelligence technologies that allow us to enrich electronic health record datasets with self-report scores in geriatrics; iii) using administrative data to model adherence to disease management and health-related behavior; iv) the use of longitudinal extension of the average attributable fraction to study health disparities and multimorbidity; and v) the geographic and racial disparities in total and remaining life expectancies after diagnoses of AD/ADRD and other chronic conditions. The increasing availability of large-scale datasets based on electronic health records and administrative claims records provide an unprecedented opportunity for obtaining nationally representative results based on individual-level measures that reflect the real care-related and epidemiological processes. This makes the reduction of barriers to entry to the use of such data of vital importance to the community of geriatrics and health researchers.

DECOMPOSITION OF DISPARITIES IN ALZHEIMER’S DISEASE AND RELATED DEMENTIA
Igor Akushevich, Duke University, Durham, North Carolina, United States

This study uses Medicare data to non-parametrically evaluate race- and place-of-residence-related disparities in AD/ADRD prevalence and incidence-based mortality, separate them out into the epidemiological causal components including race-related disparities in incidence and survival, and finally explain these in terms of health-care-related factors using causal methods of group variable effects (propensity scores and the rank-and-replace method) and regression-based analyses (extended Fairlie’s model and generalized Oaxaca-Blinder approach for censoring outcomes). Partitioning analysis showed that the incidence rate is the main predictor for temporal changes and racial disparities in AD/ADRD prevalence and mortality, though survival began to play a role after 2010. Arterial hypertension is the leading predictor responsible for racial disparities in AD/ADRD risks. This study demonstrated that Medicare data has sufficient statistical power and potential for studying disparities in AD/ADRD in three interacting directions: multi-ethnic structure of population, place of residence, and time period.

NEW AI TECHNOLOGIES TO ENRICH ELECTRONIC HEALTH RECORD DATA SETS WITH SELF-REPORT SCORES IN GERIATRICS
Ricardo Pietrobon, Spore Data, SporeData, North Carolina, United States

Although electronic health record data present a rich data source for health service researchers, for the most part, they lack self-report information. Although recent CMS projects have provided hospitals with incentives to collect patient-reported outcomes for select procedures, the process often leads to a substantial percentage of missing data, also being expensive as it requires the assistance of research coordinators. In this presentation, we will cover Artificial Intelligence-based based technologies to reduce the burden of data collection, allowing for its expansion across clinics and conditions. The technology involves the use of algorithms to predict self-report scores based on widely available claims data. Following previous work predicting frailty scores from existing variables, we expand its use with scores related to quality of life, i.e. mental health and physical function, and cognition. Accuracy metrics are presented both in cross-validation as well as external samples.

USING ADMINISTRATIVE CLAIMS TO MODEL HEALTH-RELATED BEHAVIORS: MEASURES OF SCREENING AND MEDICATION ADHERENCE
Arseniy Yashkin, Duke University, Morrisville, North Carolina, United States

We demonstrate how administrative claims records can be used to model certain behavioral patterns and associated health effects. The inability of administrative claims, which are in essence a billing record, to account for differences in behavior is a major limitation of such data which usually requires an externally linked source to overcome. However, for certain diseases, for which well-defined and accepted guidelines on screening and medication use exist, the claims themselves can provide a way for modeling health-related behavior. A practical application to screening and medication adherence for type 2 diabetes mellitus is presented. Diverse methods of the calculation of such indexes with their pros, cons and variation in identified effects are discussed and demonstrated using results based on administrative claims drawn from a 5% sample of Medicare beneficiaries.

DIFFERENCES IN THE RACIAL CONTRIBUTION OF DEMENTIA AND CHRONIC CONDITIONS TO HOSPITALIZATION, SNF ADMISSION
Heather Allore, Yale School of Medicine, New Haven, Connecticut, United States

We estimate the contribution for experiencing hospitalization, skilled nursing facility admission and mortality using a measure of attributable fraction that incorporates both the prevalence, incidence and risk called Longitudinal Extension