(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

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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 workgroup of national experts to develop new recommendations that primary care clinicians 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 clinicians 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

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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

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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