

systems change. The Dementia CMC project was a partnership (2013 – 2018) between local Alzheimer's organizations and ten managed care HPs in California. It used the following model of health care advocacy: 1) Identify dementia-capable best practices to set as systems change indicators; 2) Identify and leverage public policies in support of systems change indicators; 3) Identify and engage champions; 4) Develop and advocate for a value and business case to improve dementia care; 5) Identify gaps in dementia-capable practices; 6) Provide technical assistance, tools, and staff training to address the gaps in dementia-capable practices; and 7) Track systems change. Systems change data was collected through participant observation with HPs and interviews with key informants. HPs reported making systems changes toward more dementia-capable practices such as: better pathways for identification and diagnosis; better identification, assessment, support, and engagement of caregivers; and improved systems of referral to Alzheimer's organizations. Some indicators of systems change were inconclusive as a result of variability in HP practices and the lack of common record systems between HPs and providers. The application of this advocacy model has led to systems changes that can be replicated to improve care for people living with dementia and their caregivers.

#### COGNITIVE IMPAIRMENT TRENDS AMONG OLDER ADULTS IN A MEDICAID HOME AND COMMUNITY-BASED SERVICE PROGRAM

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Cognitive impairment (CI) is an important risk factor for nursing home admission, but little is known about CI among older adults in Medicaid HCBS programs. Racial and ethnic group CI disparities are found among community-dwelling older adults, but these CI trends have not been explored in Medicaid HCBS populations. In this study, we determined how CI is associated with older adults' racial and ethnic group identification and educational attainment in Connecticut's Medicaid HCBS program. The study cohort includes program enrollees age >65 during January-March 2019 (N=3,520). CI measures include: Cognitive Performance Scale (CPS), ranging from 0-8 (cognitively intact to very severe impairment); and a dichotomous measure incorporating Alzheimer's disease or other dementia diagnosis (ADRD) and CPS score signifying moderate or severe CI. Study cohort characteristics: 75.7% female; age, mean(sd)=79.1(8.2); Non-Hispanic White=47.8%; Non-Hispanic Black=15.9%; Non-Hispanic Other=2.7%; Hispanic=33.6%; HS education=21.7%; mean(sd) CPS score=2.7(1.9); 36.1% with ADRD/high CPS2 score. In multivariate regression models adjusting for age and sex, CPS scores were not independently associated with race and ethnicity, and the likelihood of having ADRD/high CPS scores did not differ by race and ethnicity (all p-values >0.05). In these same models, persons with more than high school education had significantly lower CPS scores (b=-.12; p<.001), and significantly lower likelihood of having ADRD/high CPS scores (AOR=0.61; p<.001), than persons with less than high school education. We conclude that educational level is independently

associated with CI, but race and ethnicity are not in this cohort. Policy and practice implications will be discussed.

#### DO INDIVIDUALS SKIMP ON HEALTH CARE AFTER SPOUSE'S DEMENTIA DIAGNOSIS?

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Dementia is a costly disease that places great burden on individuals and families. The substantial time and financial resources taken away by living with persons with dementia (PWDs) may make their spouses forgo essential health care, thus deteriorating long-term health and increasing downstream healthcare costs. However, such negative externality is understudied. This paper studied the impacts of spouse's incident dementia diagnosis on an individual's use of needed care, defined as annual flu shot and regular doctor visits for those with preexisting conditions. Using HRS linked to Medicare claims, I employed a fixed effects approach to compare the use of flu shot and doctor visit during 1 year before and after the index, for individuals whose spouse had dementia (N=691) and otherwise similar controls (N=5,073). After adjusting for time-varying health, caregiving roles, and other socio-demographic factors, spouse's dementia onset was associated with greater likelihood of getting flu shot and seeing doctors. Among those transitioning into caregiving, spouses of PWDs had a marginally higher risk of skimping on doctor visits, compared to controls (p=0.053). In this broadly representative sample, there lacks evidence for rationed health care ensuing spouse's dementia incidence, at least within a 1-year time frame. However, for new spousal caregivers, the impact of dementia is more profound and complex than deprivation of time. This group may face a trade-off between caring for spouses with dementia and caring for themselves, for whom policy support merits further study and consideration.

#### PREDICTORS OF DISENROLLMENT AMONG MEDICARE FEE-FOR-SERVICE BENEFICIARIES WITH DEMENTIA

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Medicare enrollment among people with Alzheimer's Disease and Related Dementias (ADRD) has reached an all-time high with about 12% of beneficiaries having an ADRD diagnosis. The federal government has special interest in providing healthcare alternatives for Medicare beneficiaries. However, limited studies have focused on understanding disenrollment from fee-for-service, especially among those with high-needs. In this study we identified predictors of disenrollment among beneficiaries with ADRD. We used the 2017-2018 Medicare Master Beneficiary Summary File to determine enrollment, sociodemographic, clinical characteristics and healthcare utilization. We included all fee-for-service beneficiaries enrolled in 2017 who survived the first quarter of 2018. Our primary outcome was disenrollment from fee-for-service between 2017 and 2018. Regression models included age, sex, race/ethnicity, dually eligibility to Medicare and Medicaid, chronic and disabling conditions (categorized

by quartiles), total health care costs including outpatient, inpatient, post-acute care and other costs (categorized by quartiles) and county fixed-effects. There were 1,797,047 beneficiaries enrolled in fee-for-service with an ADRD diagnosis. Stronger predictors of disenrollment included race/ethnicity and dual eligibility. Disenrollment rates were 7.9% (95% CI, 7.2 – 8.5) among African Americans, 6.6 (95% CI, 6.2 – 7.0) among Hispanics and 4.3 (95% CI, 4.2 – 4.3) among Whites. Duals were 1.9% (95% CI, 1.4 – 2.3) more likely to disenroll from fee-for-service to Medicare Advantage (MA). The inclusion of MA special need plans and additional benefits for those with ADRD and complex chronic conditions may be valuable for those beneficiaries with ADRD, and who may not have Medigap coverage when enrolling in fee-for-service.

#### RURAL AND URBAN DIFFERENCE IN LONGITUDINAL TRENDS IN PREVALENCE OF DEMENTIA IN MEDICARE CLAIMS AND SURVEY DATA

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Shortage of physicians in rural areas can lead to lower diagnosis and underestimation of dementia prevalence in these communities. We used data from the nationally representative Health and Retirement Study and a 20-percent sample of Medicare claims to study rural-urban differences in dementia prevalence. The survey dementia diagnosis is free from medical assessment while the claims diagnosis needs a physician diagnosis. We estimated the trends in dementia prevalence from (2002-2016) based on cognitive tests (using survey data) and diagnosis codes (using claims data) utilizing ordinary least squares regression. Dementia prevalence based on diagnosis codes declined in both urban and rural areas over the course of the study, with a sharper decline in urban areas. Dementia prevalence using diagnosis codes showed significantly higher rates in urban areas during all years (0.024 vs 0.018 in 2002 and 0.017 vs 0.013 in 2014 in rural vs urban areas, respectively). Dementia in the cognitive test sample was higher in rural areas (0.11 vs 0.08 in 2000 and 0.08 vs 0.7 in 2014 in rural vs urban areas), a difference that was significant only in 2004. Our results indicate lower dementia prevalence rates in rural areas in claims based sample compared to survey sample which its dementia prevalence is free medical assessment. Claims data are valuable sources for tracking dementia in the US population, however they are based on medical diagnosis. In rural areas, where there is shortage of physicians and a lack of access to health care services, claims based studies may underestimate dementia rates.

### Session 1065 (Symposium)

#### DIVERSITY OF ACTIVITIES, EMOTIONS, AND PLEASANT EVENTS AND THEIR ASSOCIATIONS WITH MENTAL AND COGNITIVE HEALTH

Chair: Soomi Lee

Co-Chair: Emily Urban-Wojcik

Discussant: David Almeida

The COVID-19 pandemic dramatically changed the structure of our daily lives. One of the most significant changes is a limited opportunity to engage in face-to-face social interactions and enjoy diverse daily activities. This raises a public health concern, because diverse experiences are critical sources of health by increasing social integration, cognitive reserve, and psychological resources. Recently, two lines of research have consistently shown that activity diversity or emodiversity is associated with multiple health outcomes. However, still more integrated efforts are needed to better understand diversity of daily experiences in various aspects and their contributions to health. This symposium brings together different endeavors towards understanding how diversity of daily experiences – activity diversity, emodiversity, and variety in positive experiences – are associated with health and well-being across adulthood. The topic of this symposium is timely to discuss potential prevention approaches to protect population well-being as the pandemic evolves. Paper 1 examines activity diversity (breadth and evenness of daily activity participation) and how it is related to positive and negative emodiversity (rich and balanced emotional experiences) differently by age groups. Paper 2 investigates the longitudinal relationship between activity variety across cognitive, physical, and social domains and cognitive functioning. Paper 3 examines variety in pleasant events and its associations with mental health outcomes. Paper 4 examines whether and how negative emodiversity is associated with mental illness during COVID-19. The discussant, Dr. David Almeida will integrate key findings from these studies, discuss their theoretical and methodological contributions, and consider opportunities for future research.

#### RICH AND BALANCED EXPERIENCES OF DAILY EMOTIONS ARE ASSOCIATED WITH ACTIVITY DIVERSITY ACROSS ADULTHOOD

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We examined whether the diversity of daily activities (“activity diversity”) is associated with the diversity of daily emotions (“emodiversity”) and if the association differs by age. Two samples of adults from the Midlife in the United States Study provided activity and emotion data for eight days. Greater activity diversity was associated with greater positive and negative emodiversity in each sample. Age moderated the association between activity diversity and positive emodiversity in an older sample, such that association was stronger for younger adults than for older adults. Results from data combining the two samples revealed that the associations of activity diversity with positive or negative emodiversity were significant when age < 70, 71 years, respectively. Broad and even participation of daily activities may provide more opportunities to experience rich and balanced emotions in adulthood. The weaker associations in older age may suggest the need to promote active lifestyles in later life.