While public health experts cannot yet say how to prevent Alzheimer’s disease and related dementias (ADRD), emerging science indicates that ADRD may be slowed through risk reduction strategies, early diagnosis, and better education and training of front-line health care professionals. Recognizing these scientific advances, the National Plan to Address Alzheimer’s Disease: 2021 Update added a new goal, Goal 6, to the 10-year-old plan emphasizing risk reduction and healthy aging: Accelerate Action to Promote Healthy Aging and Reduce Risk Factors for Alzheimer’s Disease and Related Dementias. CDC is authorized through Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer’s Act (P.L. 115-406) to create a uniform national public health infrastructure through BOLD Program and Public Health Centers of Excellence. This presentation will highlight CDC activities that not only build a uniform national public health infrastructure but also promote healthy aging consistent with Goal 6 of the 2021 National Plan.

ELEVATING HEALTHY AGING: HOW PUBLIC HEALTH IS SUPPORTING OLDER ADULTS
Karon Phillips1, and Megan Wolfe2. 1. Trust for America’s Health, Silver Spring, Maryland, United States, 2. Trust for America’s Health, Washington, District of Columbia, United States

Trust for America’s Health (TFAH) leads the national Age-Friendly Public Health Systems initiative which focuses on expanding the public health role in healthy aging. The roles of public health include creating and leading policy, systems, and environmental changes; connecting and convening multi-sector stakeholders to improve older adult health and well-being; and collecting and translating data on older adult health to inform interventions in communities and states. TFAH will share examples of how public health departments are elevating healthy aging as a core function.

SESSION 3130 (PAPER)
HOSPITAL TRANSITIONS, HEALTH CARE UTILIZATION, AND OUTCOMES OF CARE
ASSOCIATIONS BETWEEN SOCIAL ISOLATION AND HOSPITAL STAYS, NURSING HOME ENTRY, AND MORTALITY OVER TIME
Mary Louise Pomeroy1, Gilbert Gimm2, Alison Cuellar3, Emily Ihara4, and Thomas Cudjoe4. 1. Johns Hopkins University, Fairfax, Virginia, United States, 2. George Mason University, Vienna, Virginia, United States, 3. George Mason University, Fairfax, Virginia, United States, 4. Johns Hopkins School of Medicine, Baltimore, Maryland, United States

This study examined social isolation as a risk factor for hospitalization, nursing home stays, and mortality among a longitudinal sample of 12,860 community-dwelling older adults ages 65+ between 2006-2018. Using seven waves of the Health and Retirement Study (HRS) data, we examined associations between social isolation and hospitalization, nursing home stays, and mortality. Social isolation scores ranged from 0-6 using an established typology with six objective measures of social interactions: 1) marital status; 2) living arrangement; 3) monthly communication with children; 4) family; 5) and friends; and, 6) monthly participation in groups, clubs, organizations, or religious services. Covariates included fixed demographics and time-variant characteristics including loneliness, depression, Medicaid enrollment, lifestyle behaviors, activities of daily living, number of chronic conditions, and Alzheimer’s disease or related dementias. Logistic regression analyses were conducted with panel data and random effects to examine associations between social isolation and each outcome over time. About 15% of the sample was socially isolated, with an average isolation score of 1.29. Social isolation significantly increased the odds of having a nursing home stay (OR = 1.22, p < 0.001) and mortality (OR = 1.14, p < 0.001). However, it was not significantly associated with overnight hospitalizations (OR = 0.97, p = 0.09). Social isolation may put older adults at greater risk for nursing home stays and mortality over time, as compared to social integration. Policies and practices to reduce social isolation can support aging at home or the community, delay nursing home entry, and reduce the risk of mortality.

PREDICTIVE MODEL OF 30-DAY HOSPITAL READMISSION FOR PATIENTS WITH ALZHEIMER’S DISEASE
Elham Mahmoudi, Cyrus Najarian, Wenbo Wu, James Aikens, and Julie Bynum. University of Michigan, Ann Arbor, Michigan, United States

Hospitals are insufficiently equipped for patients with Alzheimer’s disease and related dementia (ADRD). Thus, 30-day hospital readmission is higher and costlier among ADRD patients than the general population of older adults. Our objective was to develop a risk-assessment tool for hospitalized patients with ADRD. We used 2016-2019 electronic medical record (EMR) data from the University of Michigan health system and applied machine learning techniques to develop a readmission risk-assessment tool. We identified 2,899 individuals with ADRD who had at least one index hospital admission. All data features available in EMR – demographics, lab results, prior counts of healthcare use, and characteristics of index hospitalization – were included in our predictive models. Additionally, we geocoded the street address of patients using the National Neighborhood Data Archive using the U.S. Census tract-level information to include two composite measures of socioeconomic status: disadvantage and affluence. The readmission rate for ADRD patients was 22% versus 17% for the general population. The best predictive model was the Random Forest (area under the receiver operating characteristic curve=0.66; sensitivity=0.64; specificity=0.61). The accuracy of our model (0.61) was 42% higher than the LACE score (0.43), which is currently used by the hospital for all patients. The top 5 predictors of 30-day readmission among people with ADRD included length of hospital stay, frailty index, living in a disadvantaged neighborhood, and total prior-year healthcare charges. Our risk-assessment tool identifies ADRD patients at high risk of readmission and why they are at higher risk. The tool enables better decision-making before discharge.