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Dually eligible individuals (i.e., eligible for Medicare and Medicaid) often have worse health and greater functional limitations than patients eligible for Medicare only. For dually eligible patients receiving inpatient rehabilitation services following a major illness or injury, improvement in function may be lower than for Medicare-only patients. To our knowledge, this is the first study to examine the relationship of dual eligibility on improvement in mobility for inpatient rehabilitation facility (IRF) patients by 13 primary diagnosis groups (e.g., Stroke, Amputation). Data was collected on the IRF-Patient Assessment Instrument at admission and discharge for all IRF patients discharged during 2017 (N = 428,631). A generalized linear model was run for each primary diagnosis group to examine the effect of dual eligibility on change in mobility during an IRF stay, adjusting for sociodemographic factors, clinical factors, and comorbidities. The proportion of patients who were dually eligible varied among primary diagnosis groups (9.6% for Hip/Knee Replacements, Fractures and Multiple Trauma to 21.7% for Amputation). Compared to patients who were non-dually eligible, dually eligible patients had lower improvement in mobility across all 13 diagnostic groups. The strongest effect of dual eligibility on lower improvement in mobility was among patients with hip and/or knee replacements (β: -1.99, $p<0.001$) and patients with non-traumatic spinal cord dysfunction (β: -1.83, $p<0.001$). This research indicates that dually eligible patients may have worse functional mobility outcomes than non-dually eligible patients for some IRF primary diagnosis groups, and these patients may need additional support after discharge.

ELDER CARE COMPLEXITIES AND OUTCOMES: A MANDATE FOR INTERDISCIPLINARY GERIATRIC CLINICAL ASSESSMENT

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Interdisciplinary geriatric assessment has long been considered best practice to identify the full range of elder care needs. In 2015, the Sanford Center for Aging launched an interdisciplinary comprehensive geriatric assessment clinic. This team-based assessment includes a geriatrician, social worker and pharmacist meeting together with each client to review all aspects of their health and well-being, resulting in a comprehensive care plan to coordinate care with the client's primary care provider. To assess this approach, a survey was conducted with 415 randomly-selected clients prior to the clinical visit, with a 6-month follow-up survey completed for 170 clients (41%), gathering data on hospitalizations, long-term care utilization and quality of life. Combining these data with clinical assessment data provides a picture of clinical complexities of elder clients and offers a mandate for comprehensive interdisciplinary care. Baseline data showed 44% hospitalized in the prior year; an average of 4 chronic conditions and 10 medications; 44% with dementia or MCI and 29% with frailty. At 6-months post-assessment, 29% reported being hospitalized, 3.5% reported moving into long-term care, and there was a slight, non-significant decrease in quality of life. These data demonstrate the profound complexities that can be identified and addressed through comprehensive assessment and care, as well as the potential to reduce hospitalizations, enable people to age-in-place and maintain quality of life. Despite the well-documented value of these approaches, Medicare and other payers have not fully embraced the opportunity to achieve these positive outcomes and remain hesitant to adequately fund comprehensive approaches to care.

PSYCHOMETRIC APPRAISAL OF THE GERIATRIC SOCIAL WORK COMPETENCY SCALE II WITH LIFELONG LEADERSHIP SKILLS

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The Council on Social Work Education (CSWE) Gero-Ed Center and Hartford Partnership Program in Aging Education (HPPAE) emphasize five competency areas specific to social work practice with older adult clientele (i.e., gero social work), namely knowledge and skills applicable to (a) values, ethics and theories; (b) assessment; (c) intervention; (d) aging programs, services and policies; and (e) leadership in aging environments. Accordingly, CSWE/HPPAE created a standardized measure – Geriatric Social Work Competency Scale II with Life-long Leadership Skills (GSWCS II) – to assess empirically these practice competencies among social work students and gero social work practitioners. A scant amount of literature exists that reports properties of this measure. Consequently, the purpose of this study was to conduct a psychometric examination of the GSWCS II, namely its factor structure and reliability among the competency areas. The sample consisted of three, advanced year MSW cohorts (N=170) from a state flagship university in the southern United States. Almost one-third of the sample were enrolled in a gerontology specialization during their advanced year. The typical participant was a 27-year-old female enrolled full time, completing the 60-credit hour MSW program. Principal axis factor results indicated unidimensionality, using the traditional 1.0 eigenvalue threshold, for each competency scale. All items loaded moderately-to-strongly on their respective competency scales; loadings ranged from 0.569 to 0.906. Regarding internal consistency for each of the competency scales, Cronbach's alphas ranged from 0.932 to 0.959; Guttman split-half coefficients (lambda-4) ranged from 0.896 to .941. Implications for gero practice competency assessment are discussed.

A LOGIC MODEL TO DESCRIBE ADULT PROTECTIVE SERVICES IN THE U.S

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The adult protective services (APS) system in the U.S. serves as an investigative and service delivery system, targeting cases of reported abuse, neglect, and exploitation of older adults and adults with disabilities. APS developed from a piecemeal investigatory system, driven by state and local processes.