

tasks independently, was measured via telephone interviews at 1, 3, and 6 months after discharge. Group-based trajectory model identified four functional status trajectories: excellent (n=29 [14.4%]), good (n=51 [25.4%]), fair (n=58 [28.9%]) and poor (n=63 [31.3%]). The most common functional trajectory by four groups was good trajectory (59%) in Group A, excellent trajectory (48.9%) in Group B, fair (50%) and poor trajectory (50%) in Group C, and poor trajectory (77.2%) in Group D. Our results suggest that most patients without disability recover functional status after pneumonia, despite multimorbidity or limited social support. Social support seems to be more important for those with multimorbidity and disability.

#### NATIONAL NORMS FOR THE ELIXHAUSER AND CHARLSON COMORBIDITY INDEXES AMONG HOSPITALIZED ADULTS

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Multimorbidity has become the defining focus of in-patient geriatric clinical practice and research. Comorbidity assessment burden is often completed using the Elixhauser (ECI) and Charlson comorbidity indexes (CCI), which can predict mortality risk, hospital length of stay and readmission, and healthcare utilization. Yet, the national norms for ECI and CCI have not been reported. Therefore, this study aimed to report comorbidity score national norms of hospitalized patients based on age, race, and sex. Using the 2017 US National Inpatient Sample, ICD-10 coding data from 7,159,694 adult patient's (≥18years) was abstracted to calculate ECI and CCI scores. Scores were stratified into 5-year age increments from age 45-89. Adults aged <45 and >89 were included in the analysis, however not age-stratified. Overall mean comorbidity score for the population using the ECI was 2.76 (95%CI 2.76, 2.76) and CCI was 1.22 (95% CI 1.22, 1.22). Mean scores for both indexes increased with age until age 90, and this increase was independent of race and sex (all p-values<0.001). Some individual comorbidities increased with age including congestive heart failure and dementia, while others including diabetes and chronic obstructive pulmonary disease increased with age but peaked between 60-74 years and declined in older age. Importantly, a report of US national norms for comorbidity burden among hospitalized adults can provide a reference for determining if clinical and research populations have greater or lesser comorbidity than typical hospitalized adults for their age, race, and sex.

#### OLDER ADULTS' PERCEPTIONS OF DISPOSITION DECISIONS FROM THE EMERGENCY DEPARTMENT

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Patient-centered care strives to improve older adult outcomes from the emergency department (ED). Appropriate

disposition decisions from the ED for older adults are becoming increasingly complex and challenging. The purpose of this study was to explore the perceptions of older adults as to their disposition from the emergency department, the decision making process, and their engagement in that process. The Three-Talk Shared Decision Making (SDM) model guided the study. A qualitative approach was used to interview seven older adults two days after being treated in the ED. Transcribed data were thematically analyzed using MAXQDA to identify codes, patterns, and themes. Analysis revealed that the Three-Talk SDM model was not being used. Participants identified only one option regarding their disposition from the ED and perceived they had little voice in decision making. They reported a variety of emotional reactions, feelings of helplessness and empathy regarding the decision making process. Three factors that participants perceived as vital to them before making a disposition decision were safety, pain relief, and a definitive diagnosis. The findings of this small sample are clinically meaningful. These older adults wanted to be heard regarding their treatment and disposition decisions. Findings indicate the need for provider education about the use of a model such as the Three -Talk SDM. Further research is needed to look at both the older adult and provider's perception of the ED disposition decision. Additional strategies and skills are warranted to enhance shared decision making in the ED with the growing aging population.

#### PAIN ASSESSMENT AND DOCUMENTATION FOR OLDER ADULTS PRESENTING WITH NON-SURGICAL CONDITIONS IN EMERGENCY ROOM

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Pain is one of the most common reasons for Emergency Department (ED) visits among older adults. However, timely pain assessment and management in this population in ED is a challenging task due to many factors ranging from; sensory, cognitive impairments, chronic pain, reliability of assessment tools, multimorbidity and system factors such as triage-based dynamic ED workflow. Where the implementation of the EMR was anticipated to improve patientcare, literature has indicated the barriers in effective utilization of the EMR for this purpose. We posit that pain assessment and documentation could be variable among older adults presenting with non-surgical conditions. Objectives:1. To examine the proportion of documented initial pain assessment of nonsurgical older adults visiting emergency department 2. To examine the number of initial pain assessments documented in the chart by the five major categories of ICD-10 diagnoses upon discharge. Methods: A retrospective exploratory chart review of 4613 emergency room visits for first pain assessment in the EMR conducted for all adults 65 years or older, presenting with non-surgical conditions, who were discharged same day at an urban teaching hospital. Results: In our study 75.72% of encounters reviewed had a documented pain assessment. Completed pain assessments for the corresponding five most common non-surgical diagnostic categories presenting to our ED: Abdominal pain (92.59%), MSK (92.11 %), chest pain (83.92%), dyspnea (80%) and falls (79.46%). Conclusion: