valid responses were analyzed. Mean age and mean working experience of the participants were 37.4 ± 9.3 and 14.0 ± 8.7 years, respectively. The 27-item DNCS-AH-v2 was developed with five factors scored on a six-point Likert scale. Cronbach's alpha was .925, I-T correlation was between .46 and .68 (p<.01), ICC coefficient (1, 1) was .76 (p<.001), and significant differences were confirmed for G-P analysis (p<.001). For the confirmatory factor analysis, fit indices of CFI =.868, GFI =.868, and RMSEA =.065 were obtained. High reliability and moderate validity were confirmed for the DNCS-AH-v2. The developed DNCS-AH-v2 could be used to evaluate dementia nursing competency in acute hospitals.

EFFECTIVE AND EVIDENCE-BASED: HOW THE 4MS AGE-FRIENDLY FRAMEWORK CAN RESULT IN IMPROVED CARE IN A RURAL PRIMARY CARE CLINIC

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As healthcare providers struggle to reframe aging, framing Age-Friendly care is also occurring. The Arkansas Geriatric Education Collaborative (AGEC) is a HRSA Geriatric Workforce Enhancement Program with an objective to improve clinical health outcomes of older adults (OA) in primary care settings. As a member of the 2020 Institute for Healthcare Improvement (IHI) Age-Friendly cohort, the AGEC has partnered with ARcare, an AR federally qualified healthcare clinic network, to implement the 4Ms in 4 rural clinics over 3 years. AGEC's first goal of working with rural primary care clinics is to improve their knowledge of best practices of caring for OA. This was started by providing Geriatric Interdisciplinary Team Training to clinic staff, obtaining baseline data of common health related indicators for OA and starting regular geriatric focused training. Training on the 4Ms (Matters, Medication, Mentation Mobility) framework was next and completed followed by planning and implementation. The process was well received and results are promising. Year 1 data in one clinic show incremental improvements over baseline data in several areas including assessing Mobility with fall screens which has improved over 50% in one year and annual wellness visits (where all 4Ms are reviewed) have increased 30%. However, several areas of opportunities for improvement have also been noted and turned into quality improvement projects (QI). This includes an opportunity to improve depression screens for the clinic's Mentation measure, which dropped almost 30% in one year. QI projects are ongoing to improve each of the elements of becoming age-friendly.

ELECTRONIC HEALTH RECORD DATA CAN BE USED AT THE BEDSIDE TO IDENTIFY OLDER HOSPITALIZED PATIENTS WITH DELIRIUM

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Delirium is a serious condition that is often underrecognized. Several delirium predictive rules can assist in early detection. The coupling of prediction rules with features of the EHR are in their infancy but hold potential. This study aimed to determine variables within the EHR that can be used to identify older hospitalized patients with delirium. This is a prospective study among patients >=65 years admitted to the hospital. Researchers screened daily for delirium using the 3-D CAM. Predictive variables were extracted from the EHR. Basic descriptive statistics were conducted. Chi-squared and Fischer's exact tests were used to compare differences among those diagnosed with or without delirium as appropriate; binary logistic regression was used for multivariate modeling. Among 408 participants, mean age was 75 years, 61% were female, and 83% were black. The overall rate of delirium was 16.7% (prevalent delirium 10.5%; incident delirium 6.1%). There was no statistical difference in 30-day mortality (2.9% vs. 2.7%) or 30-day readmission (13.2% vs. 14.7%) rates between those with and without delirium (both P>0.05). Even so, patients with delirium were older, more likely to have a diagnosis of infection and/or cognitive impairment, as well as increased severity of illness (all P's <0.05). Moreover, patients with delirium had a lower Braden score and higher Morse fall score (both P's <0.01). In multivariate analysis, cognitive impairment (OR 5.49; 95% CI 2.77-10.87) and lower Braden scores (OR 1.29; 95% CI 1.18-1.41) remained significant predictors of delirium. Further research is needed to develop an automated EHR prediction model.

ENHANCING OUR UNDERSTANDING OF TRANSITIONAL CARE PROGRAMS

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Many hospitalized older adults experience delayed discharge. Transitional care programs (TCPs) provide short-term care to these patients to prepare them for transfer to nursing homes or back to the community. There are knowledge gaps related to the processes and outcomes of TCPs. We conducted a scoping review following Arksey & O'Malley's framework to identify the: 1) characteristics of older patients served by TCPs, 2) services provided within TCPs, and 3) outcomes used to evaluate TCPs. We searched bibliographic databases and grey literature. We included papers and reports involving community-dwelling older adults aged ≥ 65 years and examined the processes and/or outcomes of TCPs. The search retrieved 4828 references; 38 studies and 2 reports met the inclusion criteria. Most studies were conducted in Europe (n=19) and America (n=13). Patients admitted to TCPs were 59-86 years old, had 2-10 chronic conditions, 26-74% lived alone, the majority were functionally dependent and had mild cognitive impairment. Most TCPs were staffed by nurses, physiotherapists, occupational therapists, social workers and physicians, and support staff. The TCPs provided 5 major types of services: assessment, care planning, treatment, evaluation/care monitoring and