

received home health (HH) care in 2017 (N=646,109). We examined the risk of hospital admission during a 60-day HH episode among Medicare home health patients in different living arrangements, including living alone at home (23.8%), living with other at home (64.8%), and residing in assisted facility (AL) facilities (11.4%). At the start of the HH episode, AL residents were older, more likely to have cognitive impairment, depressive symptoms, and limitations in activities of daily living (ADL) than those living at home (alone/with others). In the multivariable logistic regression model of hospital admission adjusting for demographic status (age, sex, race/ethnicity, Medicaid status), cognitive impairment, depressive symptoms, and ADL limitations, when compared to HH patients living with others at home (reference), AL residents were 15% less likely to have hospital admission (Odds Ratio [OR]=0.85, 95% Confidence Interval [CI]: 0.84, 0.88, $p < 0.001$). HH patients living at home alone were not statistically significantly different from the reference (OR=0.99, 95% CI: 0.98, 1.01, $p = 0.47$). HH patients in AL, despite having worse cognitive, mental, and physical function at baseline, had better outcomes than those living at home. This suggests 1) older adults living at home may have unmet health or personal care needs, and 2) synergies may exist between post-acute care through HH care and long-term care and support at AL that are critical to patient welfare.

CARE TEAM MEMBERS' PERCEPTIONS OF AN INFORMATICS INTERVENTION TO IMPROVE GERIATRIC CARE ACROSS MULTIPLE SITES

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Electronic health information exchange (HIE) may improve care for geriatric patients receiving care across multiple sites by reducing test duplication, medication prescribing errors, and adverse events. This project evaluated the implementation of an HIE intervention at two VA medical centers offering VA providers real-time notification of non-VA inpatient or ED use, followed by post-hospital geriatric care coordination. We interviewed 23 providers (physicians, nurses, social workers and other care team staff) about their experiences with the program. Interviews were analyzed using the Consolidated Framework for Implementation Research (CFIR) to examine 1) goals and expectations for notifications and transitional care; 2) barriers to effective use of notifications and coordination; and 3) suggestions for improvement. Overall, care team members were positive about the intervention, noting it cut down on time searching for outside medical records and that care coordination visits

were helpful in answering patients' questions and clarifying discharge instructions. However, some providers were not aware of the alerts, found the HIE interface challenging to use, or were concerned that expanding the program would create workflow issues. Suggestions for improvements included sharing information about newly prescribed medications, lab and radiological tests, and progress alerts during the episode of care; and including non-VA providers to facilitate care coordination. Social workers also asked to be included on alerts to improve follow-up. Our findings suggest HIE can be a useful tool for coordinating care across sites, provided information can be easily shared between all care team members and HIE interfaces are streamlined to reduce additional work.

CLINICIANS' KNOWLEDGE AND ATTITUDES ABOUT DELIRIUM DETECTION AND MANAGEMENT

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Delirium is a serious and potentially life-threatening problem, but it remains clinically under-recognized. Various factors contribute to this under-recognition, including limited understanding of delirium, insufficient training and application of delirium assessments, potential stigma for the patient and increased workload for the clinician. As a part of an NIH funded study testing a rapid two-step delirium identification protocol at two hospitals in the U.S. (one urban and one rural), clinicians completed a 12-item survey to assess their knowledge and attitudes about delirium and their confidence in preventing and managing delirium. Survey response options followed a 5-point rating scale (strongly disagree, disagree, undecided, agree, strongly agree). The sample for this analysis included 399 clinicians (MDs=53; RNs=235; CNAs=111). Chi-square was used to test for group differences between clinician types. Less than half of the clinicians reported agreeing with the statement, "delirium is largely preventable" (MDs: 47%; RN: 44%; CNA: 41%, $p\text{-value}=0.021$). MDs and RNs indicated a high level of confidence in recognizing delirium while CNAs endorsed lower levels of confidence (MDs: 87%; RN: 81%; CNA: 65%, $p\text{-value}=0.001$). All types of clinicians reported lower confidence in managing delirium (MDs: 29%; RN: 36%; CNA: 44%, $p\text{-value}=0.117$). 47% of CNAs and 37% of RNs agreed there is a need for additional training in caring for persons with delirium while only 21% of MDs agreed ($p = 0.031$). Understanding how different types of clinicians think and feel about delirium will inform training and communication initiatives, clinical implementation, and research on best practices for delirium identification and management.