of frailty. Between November 2019 and March 2020, we enrolled 92 adults who were 65 years or older and hospitalized for pneumonia at an academic medical center in Seoul, Korea. A deficit-accumulation frailty index (FI) was calculated using 50 items from comprehensive geriatric assessment (range: 0-1; higher values indicate greater frailty). The ability to perform 21 daily activities and physical tasks prior to the illness and after 30 days was self-reported. Primary outcome was death or functional decline from prior level at 30 days. The study cohort had a mean age of 79.4 (standard deviation [SD], 7.11) years, 38 (41.3%) women, and 20 (21.7%) nursing home residents. The mean FI was 0.29 (SD, 0.19), with 27 (29.4%) robust (FI<0.15), 21 (22.8%) pre-frail (FI, 0.15-0.24), 19 (20.7%) mild-to-moderately frail (FI, 0.25-0.44), and 25 (27.2%) severely frail (FI≥0.45) categories. Among 71 patients without maximum disability at baseline, 8 (11.3%) died and 39 (54.9%) experienced functional decline. The 30-day risk of primary outcome for increasing frailty categories were 47.8%, 57.9%, 77.8%, and 81.8%, respectively (p-for-trend=0.022). Our results indicate that pneumonia is a major disabling illness in older adults with frailty. A proactive geriatric evaluation and multidisciplinary intervention are needed to improve functional recovery in these patients.

DECREASING EMERGENCY ROOM UTILIZATION IN HIGH RISK GERIATRIC PATIENTS

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Background: The Acute Life Interventions Goals & Needs Program (ALIGN) at the Mount Sinai Hospital in New York City aims to work closely with high risk geriatric patients for short term intensive management of acute medical and social issues. Quantitative measures for determining success of the program is comparing emergency room visits and hospitalizations prior to and after enrollment with ALIGN. The Community Paramedicine service allows a paramedic, the ALIGN provider, and an emergency room physician to assess and triage patients in their home via video conference thereby avoiding ED visits for non-urgent services. Method: We reviewed the utilization of the Community Paramedicine service (from July 2017-February 2020) and its impact on ALIGN's efforts to reduce unnecessary ED visits and hospitalizations. Results: 36 patients were evaluated with the Community Paramedicine service (from July 2017-February 2020). 19 or 52.8% avoided an ED visit and 17 or 47.2% were transported to the ED. 12 or 70.6% were admitted to the hospital of those that were transported to the ED initially. Top reasons for transport to ED included generalized weakness, acute mental status change (AMS), and shortness of breath (SOB). Conclusions: A Community Paramedicine program utilized by a high risk geriatrics team like ALIGN is effective in reducing ED visits and hospitalizations for the elderly population who incur greater expenses to the health care system and traditionally have poorer health outcomes.

DELAYED HOSPITAL DISCHARGE–THE EFFECT OF DEMENTIA AND GP CONTACTS PRIOR TO HOSPITALIZATION

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Delayed hospital discharge, also known as alternate level of care (ALC) in Canada, refers to a stay in hospital when acute services are no longer needed but the patient occupies a hospital bed while waiting to be discharged to an appropriate care setting. ALC has negative consequences for both the service system (high costs, inappropriate use of hospital resources) and individuals (feelings of uncertainty, functional loss). Extensive administrative health care data from British Columbia, Canada, were employed to study differences in ALC between people with and without dementia in 2001/02, 2005/06, 2010/11 and 2015/16, and whether continuity in physician–patient relationships prior to hospitalization is associated with ALC. We analyzed designation of ALC and length of stay in ALC, using generalized estimating equations logistic regression and negative binomial regression analysis. Of all individual, residential area and health care related factors, dementia was the single most important factor increasing the odds of designation of ALC (OR 4.76, 95%CI 4.59, 4.93). Dementia also added to the length of stay in ALC. Proportion of patients designated to ALC increased over the study years. Higher number of visits to the same general practitioner (GP) prior to hospitalization decreased the odds of ALC, especially in people with dementia. As populations age, the number of people with dementia is increasing. Efforts to control ALC have resulted in greater concentration of ALC among people with dementia. Higher continuity GP care may be a way to help understand and control these trends.

DEMENTIA NURSING COMPETENCY SCALE AT ACUTE HOSPITALS VERSION 2: DEVELOPMENT AND PSYCHOMETRIC EVALUATION

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Under an increasing number of people with dementia worldwide, the number of patients with dementia in acute settings is also growing. For patients with dementia to receive treatment with peace of mind, nurses should have competency in caring for patients with dementia. Thus, the aims of this study were to develop the Dementia Nursing Competency Scale in Acute Hospitals version 2 (DNCS-AH-v2) and to evaluate its psychometric properties. The draft was distributed to a convenience sample of 3000 nurses at 300 acute hospitals. After confirming the ceiling effect and the floor effect, reliability and validity were verified using Cronbach's alpha, I-T correlation, test-retest reliability, G-P analysis, and exploratory and confirmatory factor analyses. This study was approved by the Institutional Review Board of Kobe University. Of a total of 3000 nurses, 878 (29.3%) responded to the questionnaire and 773 (25.8%)