

to hospital and were hospitalized in internal-medicine units. Demographic, functional, cognitive, psychological and mobility characteristics and symptoms' disturbance were assessed within the first 24 hours of admission and one month following discharge. Cluster analysis identified three distinct subgroups based on patients' experiences with five highly prevalent symptoms (tiredness, dyspnea, dizziness, sleep disturbance and pain): Low or high levels of all five symptoms (70%, 14%, respectively), and moderate levels of four symptoms with high dyspnea (14%). "All high" cluster was characterized by the worst cognitive and instrumental function, and highest anxiety and depression levels. The "moderate with high dyspnea" subgroup expressed the highest comorbidity score. Multivariate Logistic regression showed that the odds of decline in instrumental ADL one month post-discharge was 3.28 (95% CI 3.21-3.25, $p=.021$) for "all high" and 2.35 (95% CI 2.33-2.36, $p=.043$) for "all low" symptom-subgroups compared to "medium with high dyspnea" subgroup adjusted for pre-morbid function, health conditions and demographic characteristics. Belonging to certain symptom-subgroups is an important risk factor in predicting negative consequences of hospitalization. These findings emphasize the importance of evaluating and subgrouping broad range of symptoms among hospitalized older adults.

CHARACTERISTICS OF HOSPITALIZED OLDER ADULTS WITH RECURRENT CLOSTRIDIUM DIFFICILE: INTERVENTION OPPORTUNITIES

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Clostridium difficile infection (CDI) is the leading cause for gastroenteritis-associated deaths (Hall et al., 2012). Risk factors include advanced age, antibiotic use, and hospital admission, yet multiple others are not widely known. CDI recurrence risk may be as high as 40% after initial treatment (Garey et al., 2008; Kelly & Lamont, 2008). Older adults may present atypically, and treatment guidelines for initial and recurrent CDI have evolved from older standards. A retrospective cohort research study explored characteristics of hospitalized adults ages 55 and older with CDI between December 31, 2013 through December 31, 2015, identified by ICD diagnosis codes. Recurrence within one year, laboratory measurements, chronic diseases, and psychosocial data were captured from the electronic health record (EHR). Over the study period, 871 patients had a recurrence rate of 23.9% ($n=208$). Caucasian females comprised over half the sample, and 9.1% expired during initial hospitalization. Almost two-thirds ($n=576$, 66.1%) lived in private residences prior to admission. CDI recurrence was more prevalent if discharged to skilled nursing facility and home health care services. Hypertension, heart failure, and chronic kidney disease were most prevalent in the recurrent CDI group. Polypharmacy was noted in over two-thirds of sample. A large portion of the sample displayed hypoalbuminemia on admission. Utilizing the EHR to aggregate data promotes interventions to reduce recurrence, prolonged stay, and aggressive treatment per current guidelines. Multidisciplinary

approaches include deprescribing, nutritional support, and chronic disease management. Person-centered care and individualized interventions should begin on admission with close outpatient follow-up and hopeful reduced readmissions.

PROLONGED MECHANICAL VENTILATION: CHARACTERISTICS OF PATIENTS TREATED AT HOME COMPARED TO HOSPITAL LONG-TERM CARE

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Rising numbers of patients receiving Prolonged Mechanical Ventilation (PMV) pose a challenge, and advancing technology supports ventilators appropriate for either Home or Hospital Long Term Care (HLTC). Data guiding decisions concerning place of care are lacking. This study describes the characteristics of the majority (120/123) of all PMV patients aged ≥ 18 (and their caregivers) in Jerusalem, covered by the Clalit Health Service, treated either with Home Hospital or HLTC. Patients were more alert and communicative at Home vs. HLTC (40/46 vs. 22/74), younger (54 vs. 73 years, $p=0.12$), and without legal guardian (59% vs. 12%, $p<0.01$). Primary reason for PMV at home was degenerative neuromuscular disease (59% vs. 28%), compared to post resuscitation/sepsis/CVA in HLTC patients (17% vs. 62%), who suffered more comorbidity, functional decline post-PMV, and pressure sores (0% vs. 42%). Ventilation was more likely to be planned at home vs HLTC (33% vs. 8%), and yet 119/120 were without Advanced Directives prior to PMV. Caregivers at home tended to be spouses (48% vs. 31%) and offspring at HLTC (17% vs. 47%), with reduced Modified Caregiver Strain Index at home (10.5 vs. 12.9, $p=0.12$). Mortality during follow-up was lower at home (15.2% vs. 27%). Costs to the health fund for home versus HLTC were approximately 1:3. Our findings suggest that with appropriate targeting of eligible PMV patients, Home Hospital may be the preferred model of care for patients, caregivers and healthcare providers.

WELL-BEING AND ADVANCE DIRECTIVES AMONG PROLONGED MECHANICAL VENTILATION PATIENTS AT HOME VERSUS HOSPITAL

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Despite increasing numbers of older patients requiring Prolonged Mechanical Ventilation (PMV), little is known concerning their mood, well-being, distressing symptoms and attitudes towards ventilation. Furthermore differences may exist according to place of care- whether Home Hospital or Hospital Long Term Care (HLTC). These issues were addressed using the revised Edmonton Symptom Assessment System (r-ESAS)(10 items, max severity score=100), and Short Geriatric Depression Scale, in a study of the majority of PMV patients ($n=120/123$) aged ≥ 18 (range 18-96 years) all Clalit