the 5 M's model on mobility, medication, mentation, multimorbidity, and what matters. Case management staff were given age-sensitivity trainings, improved workflows and made assessments that identified, addressed, and secured resources for patients throughout their hospitalization. Silver Angel volunteers were specially trained to prevent physical and mental decline and focused on activities to prevent delirium, depression and falls. The volunteers visited with patients daily for these interactions. The initiative was piloted in April 2020 on a stroke telemetry unit and since then the hospital has seen a significant decrease in the overall annual readmission rates by 3.1% when compared to 2019. The average length of stay for older adult patients; however, increased from 4.05 to 4.83 days unfortunately due to COVID-19. This initiative demonstrates the necessity to expand "65 & Thrive" throughout the hospital and ultimately to other Kaiser Permanente medical centers to best provide holistic care to older adults.

A DELIRIUM RISK STRATIFICATION TOOL AND INTERDISCIPLINARY ROUNDS TO PREVENT DELIRIUM IN HOSPITALIZED OLDER ADULTS

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Delirium is a disturbance of attention accompanied by a change in baseline cognition that is commonly seen in acute care settings, and effects up to 80% of ICU patients. The development of delirium has adverse effects on patient outcomes and high health care costs. Of patients aged 65+ admitted to our hospital in 2019, non-delirious patients had a five-day length of stay (LOS) compared to a 10-14 days LOS in delirious patients. A five days LOS increase adds an additional $ 8,325 per patient for an extra annual cost of 15 million dollars. Additionally, delirium is often not recognized. A prior retrospective study showed that 31% of older adults seen by a Geriatrics provider were diagnosed with delirium, while only 11% were detected by nurse's CAM screen. Given the need to improve delirium detection and management, a QI project was undertaken with a goal to recruit an interdisciplinary team, create a risk stratification tool to identify patients at substantial risk for developing delirium, and develop a delirium prevention protocol. Patients with a score of ≥ 4 were initiated on a nurse driven delirium protocol that included a delirium precaution sign and caregiver education. 6 months data has shown increased delirium detection of 33%, a reduction in 7.7 days LOS, reduced SNF discharge by 27%, and a significant LOS saving of 231 days. The results were statistically significant, $p < 0.04$ for LOS reduction. The cost avoidance in LOS alone were $384,615 for delirium patients.

ARE STAKEHOLDER PRIORITIZED POST-ACUTE CARE PRACTICES DOCUMENTED AND DO THEY IMPROVE OUTCOMES?

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The receipt and intensity of rehabilitation services, such as occupational and physical therapy, have been associated with lower risk of readmissions. Yet, little is known about the care. This study quantified the frequency of documented post-acute care (PAC) stakeholder-prioritized practices and their associations with hospital readmissions. A PAC stakeholder advisory board (e.g., physicians, rehabilitation providers across settings) prioritized key practices to evaluate. Medicare claims and electronic medical records were used to construct an episode of care for patients age 65 or older. Eligible patients were discharged from one of nine acute hospitals to a PAC setting (i.e., inpatient rehabilitation, skilled nursing, home health) within one large health system between August 2016 and August 2018. Descriptive statistics characterized the cohort and frequency of documented practices. Logistic regression examined associations among the practices and readmissions, by setting. Stakeholders prioritized (a) education, (b) cognition assessment and treatment, and (c) medication management. Among these PAC patients (n=3,227) there was variation in documentation for each practice by setting. Documentation of medication management at any point during the stay ranged from less than 1% to 54% of patient stays among settings. There was a significant relationship between the practices and readmissions. Within inpatient rehabilitation, every additional day patient and caregiver education was documented by occupational therapy was associated with 21% lower odds of readmission ($p<0.05$). This study highlights the variability in documentation of stakeholder-prioritized practices across PAC and their associations with readmissions. Future work is needed to enhance the systematic delivery and documentation of these practices.

CHANGES IN FUNCTIONAL STATUS AMONG CLUSTERS OF OLDER ADULTS AFTER HOSPITALIZATION FOR PNEUMONIA

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Little is known about how social determinants, comorbidity, and disability status are associated with functional recovery after an acute illness. A prospective cohort study was conducted between 2019-2020 at a university hospital in Korea, to investigate functional recovery after hospitalization for pneumonia in older adults with different degrees of social deprivation, disabilities, and comorbidities. K-means cluster analysis was used to identify groups of patients based on social deprivation score, activities of daily living, instrumental activities of daily living, physical limitation score, and Gagne comorbidity index. Four groups were identified: Group A: non-disabled group with limited social support (n=61 [30.3%]); Group B: multimorbid but non-disabled group with social support (n=45 [22.4%]); Group C: multimorbid and disabled group with social support (n=38 [18.9%]); Group D: multimorbid and disabled group with limited social support (n=57 [28.4%]). Functional status, defined as ability to perform 21 activities and physical

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: