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

discharge planning. The outcomes most frequently assessed were discharge destination, mortality, hospital readmission, length of stay, cost and functional status. TCPs that reported significant improvement in older adults' functions (which was the main goal of the TCPs) included multiple services delivered by multidisciplinary teams. There is a wide variation in the operationalization of TCPs within and between countries.

HOME HEALTH CARE PRACTICES TO REDUCE ACUTE-CARE HOSPITALIZATIONS

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Avoidable acute-care admissions are linked to negative health outcomes for patients and are costly to insurers. Home health care agencies (HHAs) are important players in preventing these admissions. Research on best practices to prevent acute-care admissions in the home health care context is limited. The purposes of this study were both to discover what practices HHAs are implementing in Medicare-certified home health care episodes to prevent acute-care admissions, and to learn what barriers HHAs face in implementing these practices. This study used mixed methods including qualitative and quantitative elements. Seven key informant interviews were used to develop a web survey that was emailed to all Medicare-certified HHAs in Massachusetts (response rate 12.43%, n=23). Using qualitative methods including thematic review, open-coding, and member-checking this study developed a four-categorization method. The categories are assessment, interventions, communication, and global practices. The study also developed a taxonomy for describing barriers to implementing practices. The distribution of responses for the new taxonomic categories were: patient-related (32.35%), staffing-related (29.41%), software-related (17.65%), physician/hospital-related (14.29%), and reimbursement/regulation-related (5.88%). This study fills a gap in research by describing the realities of home health care practice in the context of avoidable acute-care admissions. The categorization of best practices and the taxonomy of barriers developed in this study provide frameworks for understanding HHA practice. Further research is needed to effectively reduce avoidable acute-care admissions during and after Medicare-certified home health care episodes.

HOSPITAL DISCHARGE INTERVENTIONS: A COST-SAVINGS COMPARISON

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For an older patient, transitioning back into the community after an acute health incident is a critical juncture. Avoidable acute-care readmissions are expensive for hospitals and federal programs. Negative health outcomes for patients and negative financial outcomes for hospitals and federal programs have focused attention on effective discharge interventions to improve care transitions and decrease avoidable acute-care readmissions. This study compares cost and readmissions outcomes from peer-reviewed publication data for three discharge interventions: Care Transitions Intervention (CTI), Project RED (ReEngineered Discharge), and the Transitional Care Model (TCM). This study adjusted costs to 2015 rates and compared cost savings per patient, return on investment (ROI) and percent reduction of readmissions. Cost savings per patient (2015-adjusted) were found for all interventions: CTI ($152.89); Project RED ($327.03); TCM ($1565.84). ROI was positive for all interventions: CTI (832%); Project RED (535%); TCM (232%). Compared to control groups, intervention group readmissions were 3.6% lower for CTI (n.s.), 5.5% lower for Project RED ($p<.05$), and 13.2% lower for TCM ($p<.05$). These three discharge interventions differ in scale and intensity, but they all show cost savings and reductions in readmissions. The lower-cost intervention shows cost savings and ROI (CTI), and the more resource-intensive interventions (Project RED and TCM) reduce costs and statistically significantly reduce rates of readmission. Even with small budget dollars, hospitals have options for finding an effective discharge intervention to reduce costs and readmission rates.

HOSPITALIZATION AND SUCCESSFUL AGING OF COMMUNITY-DWELLING OLDER ADULTS: USING THE KOREAN NATIONAL SURVEY DATA

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Hospitalization experience can be an obstructive factor to successful aging. Although older adults who had hospitalization experience has been considered to have poor health status and low participation in one's life, it is not obviously evident whether hospitalization itself affects successful aging. This study aimed to investigate whether three components of successful aging (i.e., diseases and disease-related complications, physical and mental functions, and engagement with life) were different in community-dwelling older adults who had hospitalization experience for the past one year compared to the counterpart older adults without hospitalization experience. A secondary data analysis was performed using a nationally representative survey data in Korea. A total of 1,812 who had hospitalization experience were matched to 1,812 control counterpart using propensity score matching. Sampling weight of the survey was considered for all statistical analysis. The community-dwelling older adults with hospitalization experience were less likely to be aging successfully than the older adults without hospitalization experience. The older adults with hospitalization experience had more chronic illnesses and malnourishment; they had more impairment in physical function and depressive symptoms; they were less active in working, social activities, and traveling. However, there were no differences in cognitive function and religious activities between the groups. In conclusion, the community-dwelling older adults who had hospitalization experience have poor health status and less engagement in one's life in general after matching covariates using propensity score matching analysis. Therefore, more attention and assist are needed to the community-dwelling older adults with hospitalization experience to facilitate successful aging.