Health Service insurere, in Jerusalem. Communicative patients were interviewed (40/46 at home, 227/4 in HLTC, average age 54 vs.73 years, p<0.01). The following symptoms (dichotomous to “not-a-problem”/“problematic”) were frequently reported as “not-a-problem” among patients (Home,HLTC): tiredness (59%,58%), poor appetite (95%,90%), pain (69%,84%), drowsiness (77%,90%), nausea (85%,84%), and shortness of breath (82%,90%). General well-being (categorized to good/mild/moderate/severe impairment) was reported more frequently as good or mildly impaired at Home vs. HLTC (54 % vs.26 %), as was lower frequency of depression (34.4 % vs. 44.4 %, p=0.049). The total p-ESAS score was similar irrespective of setting: Home-24.9/100 (inter quartile range [IQR] 13.5-32.5) vs. HLTC-23.7/100 (IQR 17.5-32), p=0.74. The majority (119/120) of patients were without advanced directives prior to initiation of PMV. When asked if they had to choose again, 82% and 91% of communicative patients at home vs. HLTC would opt again for ventilation, as would 75% of caregivers of uncommunicative patients. Our findings emphasize the resilience and low levels of distressing symptoms among PMV patients, and may contribute to the decision-making process concerning advanced directives.

INNOVATIONS IN EMERGENCY MEDICAL CARE:
EARLY ADOPTERS OF GERIATRIC EMERGENCY DEPARTMENTS
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Hospital emergency departments (EDs) treat more than 20 million older adults each year making it a remarkably significant site of healthcare delivery. To date, the nation’s nearly 5,000 EDs have been slow to modify their staffing, ED training, procedures, or physical environment to better serve the unique needs of this heterogeneous older adult population. Nonetheless, nationwide a small set of innovative EDs have redesigned their care and now promote themselves as Geriatric Emergency Departments (GEDs) which specifically tailor care to older adults and their families. Using a systematic, nationwide search process of U.S. hospitals, this research identified n=83 EDs which clearly self-identified as GEDs. All eligible GEDs were contacted with n=54 (65%) responding to our self-administered survey regarding their organization, delivery of care, and adherence to national guidelines on the emergency medical care of older adults. Results document a wide variety of care models, staffing patterns, screening procedures, clinical care modifications, quality improvement efforts, physical environment enhancements, referral patterns, and tracking of older patient outcomes. Analysis of open-ended responses demonstrated widely divergent interpretations of the national guidelines on emergency care for older adults including the definition of a GED. Based on the findings, research recommendations are made to researchers regarding the conceptualization and specific wording of future survey items in order to increase the reliability and validity of research into GEDs.

GERIATRICS MICU CO-MANAGEMENT
INTEGRATING GERIATRIC ASSESSMENTS FOR CRITICALLY ILL PATIENTS
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Programs like orthogeriatrics, geriatric cardiology have shown to improve outcomes in hospitalized geriatric patients. Our Geriatrics MICU Co-management program is a quality improvement initiative that instigates a partnership approach with critical care medicine in integrating geriatric assessments and build foundation for interdisciplinary care of critically ill patients. MICU (Medical Intensive Care Unit) protocols do not have standard geriatrics assessments integrated in clinical care. An electronic dash-board identifies high risk elderly (HRE) patients admitted at a MICU in a large teaching hospital in Northeast Ohio based on nursing specific screening triggers. A geriatrics co-management team engages in a comprehensive geriatric assessments and care transition. 386 patient were identified using HRE screening triggers in a period of 100 days. 33 % (n=131) were generated as consults for co-management. A pilot review on HRE patients was conducted. 70% (n=93) patients had incident frailty. 93% (n=87) of patients with frailty were diagnosed with incident delirium. 56% (n=74) of patients were newly diagnosed with cognitive impairment. 56 % (N=74) of patients had a medication reduction. An average of 1.23 medication was changed. 85% (n =112) of patients had a warm hand off to the next level of provider on discharge. 90% (n=119) of patients notified improved self-management skills and better understanding of discharge process. The Geri-MICU program demonstrates a patient -centered approach in integrating geriatric assessments for critically ill patients and build foundation of a geriatrics-critical care task force. The program would be a mile stone in optimizing elderly care in critical care units.

GENERALIZABILITY OF CLINICAL TRIALS OF DELIRIUM INTERVENTIONS
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Delirium, or acute confusional state, affects up to 7 million hospitalized older adults annually, and is associated with increased risk of mortality, institutionalization, and cognitive and functional impairment. There has been a proliferation of both pharmacological and nonpharmacological clinical trials to reduce the incidence and sequelae of delirium. In other neuropsychiatric disorders, exclusion criteria prevent up to 75% of individuals with the condition under study from participating. It is unclear how well these trial samples represent the population of older adults with delirium. We selected all intervention trials registered at ClinicalTrials.gov containing the keyword “delirium” (N=131), regardless of type of intervention. We manually examined study descriptions to restrict analysis to studies with delirium as a primary or secondary outcome (N=92). Of these 92 studies, 76% enrolled only adults, with 45% enrolling only older adults. 38% of studies were restricted to surgical units, 27% to intensive care units, and 7.6% to medical units. Only 1 study examined nursing homes and 4 studies examined palliative care. 50% of studies excluded individuals with pre-existing dementia, 28% excluded individuals with psychiatric disorders, and 30% excluded individuals with neurological disorders. 34% of studies excluded individuals with alcohol or drug abuse. Overall, many intervention studies for delirium
are limited to the surgical and ICU populations, and they exclude individuals with common comorbidities associated with an increased risk of delirium. Similar to other neuropsychiatric disorders, these findings raise significant concerns about the generalizability of clinical trials in delirium to the hospitalized older adult population.

PREDICTORS OF PRESSURE ULCER DEVELOPMENT AMONG SENIORS DURING EMERGENCY TRANSFERS TO HOSPITAL EMERGENCY DEPARTMENT
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Emergency transfers of seniors in long-term care facilities (LTCF) aged >65 to hospital emergency departments (ED) are common and carry with them risks that can lead to less-than-optimal quality of care and quality of life. Pressure ulcers are one such risk. We used data from the Older Persons Transitions in Care (OPTIC; N=637) study, conducted in two Canadian provinces in 2011 and 2012, to assess potential predictors of pressure ulcer development between the time that a resident is transported to the ED until the time they return to their original nursing home. Step-wise binary logistic regression was employed to identify predictors of pressure ulcer development during the transition. Potential predictors included length of transition, inpatient status, demographic, health variables (including incontinence). Among the 335 residents for whom we were able to gather new pressure ulcer data, 56 (16.7%) were identified as having developed new skin wounds upon return to the LTCF. Transitions from ED admission to return to LTCF averaged 106.7 hours (sd=143.6) with a median of 50.0 hours. Length of transition and whether the resident spent time as an inpatient emerged as the only predictors: longer transition times and spending time as an inpatient predict development of bed sores. These results speak to the need for improved monitoring and treatment of skin wounds during emergency transitions of older adults from LTCF.

SESSION 2320 (POSTER)

ADULT PROTECTION | ELDER ABUSE

IMPROVEMENTS NEEDED FOR JAPANESE ELDER ABUSE PREVENTION LAW: COMPARISONS WITH OTHER ABUSE PREVENTION LAWS
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Japan has four stand alone abuse prevention laws, including child abuse (enforced in 2000), domestic abuse (2001), elder abuse (2006) and abuse for people with disabilities (2011). These laws are distinctive in that they aim to prevent abuse, not merely to address abuse after it occurs. This paper compares components of these four abuse prevention laws, delineating major strengths and weaknesses of the elder abuse prevention law in comparison to the other three. The analysis considers both institutional and domestic settings and suggests possible improvements of elder abuse prevention law that need to be made. Evidence for this analysis is supplied through examination of trends abuse using longitudinal data (2012-2017) collected by Japan’s Ministry of Health, Labour and Welfare. The analysis shows commonalities in trends in the four abuse categories. For example, the number of abuse cases has risen over time despite the dissemination and implementation of abuse prevention training, program implementation, and public outreach. Differences include reporting – police more often report abuse cases of children and people with disabilities, while elder abuse cases are more often reported by professional staff members responsible for dealing with elder abuse cases. Although some amendments have been made to the child abuse and domestic abuse prevention laws, no amendments have been made to the elder abuse prevention law despite the requirement to review its success. Needed revisions include provisions of protection orders and temporary shelters to protect elder victims from abusers as soon as possible.

ELDER ABUSE BY FAMILY CAREGIVER: DOES COGNITIVE IMPAIRMENT REALLY MATTER?
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Previous research suggested that cognitive impairment is a risk factor for elder abuse. Persons with dementia experience elevated risk of abuse as compared to the general aging population. The present study compared rates of abuse reported by family caregivers of older persons with and without dementia. A total of 693 family caregivers participated, among which 592 were providing care older persons with dementia and 101 were providing care to older persons without. Participants provided information on their demographic characteristics, care recipient physical functioning (Instrumental Activities of Daily Living), behavioral problems (Cohen Mansfield Agitation Inventory), caregiver stress (Zarit Burden Interview), emotional and instrumental social support, and abusive behaviors directed at the care recipients (Conflict Tactics Scale and Potentially Harmful Behaviors). Abuse is common in this sample: 46.8% reported potentially harmful behaviors, 52.7% reported psychological aggression, 11% physical assault, and 1.3% injury. No significant difference was observed between caregivers providing care to older persons with or without dementia (p>.05). A series of logistic regression was conducted to determine factors associated with abuse. Care recipient behavioral problems and caregiver burden were two prominent factors associated with potentially harmful behaviors and all forms of abuse. Behavioral problems are common in persons with cognitive impairment and many caregivers feel stressful managing them. It is plausible that cognitive impairments per se do not increases risk of abuse, but the associated characteristics do. Helping family caregivers manage the caregiving situation and their expectation, positive appraisal and cognitive restructuring may help prevent elder abuse.

CRIME-RELATED PHYSICAL INJURIES AMONG OLDER ADULTS IN THE UNITED STATES: FINDINGS FROM 2015 NIBRS DATA
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