torque (extension), a muscle's maximum strength capability, was significantly higher in White cases and Blacks controls compared to Blacks cases. Novel findings revealed that baseline pain is much higher and functional performance is significantly lower in Blacks with OA compared to White cases and Black controls. This research advances precision pain measurement and our understanding of the biological mechanisms uniquely involved in the experience of knee OA and mobility.

**MEDICAL COMPLEXITY, MORTALITY AMONG HIGH-COST MEDICARE ADVANTAGE ENROLLEES: PALLIATIVE, HOSPICE IMPLICATIONS**

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Older adults with high medical spend require tailored interventions and care delivery to meet their complex needs. Palliative is a high-value solution for high-cost patients because it provides relief from the symptoms, pain, and stress associated with multiple conditions. Likewise, other high-cost patients may be closer to end-of-life and therefore benefit from hospice care. For Accountable Care Organizations (ACOs) and hospitals to implement palliative care, these programs must identify and target the high-need patient populations. This study explored patterns of spending and mortality across 4 years (2016-2019) using claims from 1,701,647 patients continuously enrolled in UnitedHealth Group Medicare Advantage (mean age=73.7; S.E.=0.01). Patients with healthcare spend in the top decile were segmented into three subgroups based on health conditions and spend patterns. Analyses identified a subgroup of patients (mean age=76.6; S.E.=0.04), with the highest rate of mortality, and significantly more chronic conditions and frailty, indicating their cost and mortality was driven by medical complexity. Odds ratios from a multinomial logistic model tie blood formulation drugs (OR XX), medlicative procedures (OR XX), and nonhospital-based care (OR XX) to members of this subgroup may be connected to short-term mortality. There is a critical need to identify patients who stand to benefit from palliative and end of life care, this is particularly true for high-cost high-need patients. Our study suggests that patterns of medical complexity and mortality within high-cost patient subpopulations can be used to identify high-cost patients who would benefit from palliative or hospice care.

**MISSING OPPORTUNITIES FOR COMPASSION: A CALL TO ACTION FOR INCARCERATED INDIVIDUALS DENIED COMPASSIONATE RELEASE**

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In 2016, a total of 4,117 state and federal prisoners died in publicly or privately operated prisons. Each year from 2001 to 2016, an average of 88% of deaths in state prisons were due to natural causes, with more than half of those due to cancer, heart disease or liver disease, conditions for which non-incarcerated citizens often benefit from palliative care and hospice. Prisoners age 55 and older are the fastest-growing segment of the population residing in prisons, as well as those with the highest mortality rate. Compassionate release of seriously ill prisoners became a matter of federal statute in 1984 and has currently been adopted by the majority of U.S. prison jurisdictions. The spirit of the mandate is based on the idea that catastrophic health conditions terminal illness affect the four principles of incarceration: retribution, rehabilitation, deterrence, and incapacitation. Concerned about an aging prison population, overcrowded facilities, and soaring costs, many policy makers are calling for a wider use of compassionate release for persons with terminal illness as well as broader prison reform. The prognosticating criteria of compassionate release guidelines are clinically flawed, and the application and procedural barriers are prohibitive. In this paper we review cases of patients who qualified for compassionate release but had their applications denied. We will discuss the urgent need for access to quality palliative medicine for incarcerated persons with advanced illness and call healthcare providers to action with the aim of reducing suffering and promoting social justice for those in need.

**PREVALENCE OF MUSCULOSKELETAL PAIN AND ANALGESIC TREATMENT AMONG HOME-DWELLING OLDER ADULTS: CHANGES 1999–2019**

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Pain has been shown to be undertreated in the older population. At the same time, the increased opioid use is of concern in the Western world. This study analyzes temporal trends in pain management among home-dwelling people aged 75 to 95 using cross-sectional cohort data spanning 20 years. The Helsinki Aging Study recruited random samples aged 75, 80, 85, 90, and 95 in 1999, 2009, and 2019. In total, 5,707 community-dwelling people participated in the questionnaire survey. Participants reported their medical diagnoses, regular prescription medications, and the presence of back pain or joint pain within the last 2 weeks (never, sometimes, or daily). We compared analgesics use in people reporting musculoskeletal pain and in people not reporting pain in 1999, 2009, and 2019. Of participants, 57–61% reported intermittent or daily musculoskeletal pain. The percentage of people taking a daily analgesic increased from 9% in 1999 to 16% in 2019. The use of NSAIDs decreased from 1999 to 2019, while the use of paracetamol increased from 2% to 11%. Of participants, 3% took daily opioids in 2019. Of those reporting daily musculoskeletal pain, 20% in 1999, 35% in 2009 and 32% in 2019 took regular pain medication. Pain remains undertreated in the older population, although the use of regular prescribed analgesics increased

QUALITATIVE ANALYSIS OF PATIENT’S HEALTHCARE TRAJECTORY WITH AND WITHOUT PALLIATIVE CARE
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Palliative care is important to the care of seriously ill patients to support the patient and family. Palliative care is often timely in the inpatient setting, but delayed in outpatient care, leading to missed opportunities. Identifying when to engage patients with palliative care in outpatient settings has been challenging. As part of a larger quality improvement project to increase access to palliative care, a qualitative sub-study was completed to identify missed palliative care engagement opportunities in patient’s healthcare trajectories. A document analysis of patients notes from a convenience sample of 20 recently deceased patients who received care within the Veteran Affairs healthcare system (VAHCS) was completed. Patients were sorted into four categories that emerged from initial analysis: cancer/palliative, non-cancer/palliative, cancer/non-palliative, and non-cancer/non-palliative. Two qualitative analysts reviewed the notes, paying particular attention to notes preceding or following seminal healthcare events. Patients in the cancer/non-palliative category were more likely to decline preventive care, engage less with the VAHCS health care or only interacted with the VAHCS for specific needs (e.g., determine VA health benefits). Similarly, non-cancer/non-palliative care patients were more likely to use a mix of VAHCS and outside healthcare, with inpatient care occurring outside of the VAHCS. For non-palliative care patients, seminal healthcare events were less likely to occur in the VAHCS. Thus, identifying opportunities to engage patients with palliative outside of seminal healthcare events may be important to increasing patient access within the VAHCS.

RELIABILITIES OF MEAN AND VARIABILITY OF AMBULATORY PAIN AMONG COMMUNITY DWELLING OLDER ADULTS
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Individual’s pain experiences vary substantially over time periods, and the variability in pain may be an important metric to predict health consequences. However, research on its reliability is lacking among older adults. We aimed to examine the reliabilities of both intra-individual mean (IIM) and intra-individual variability (IIV) of subjective pain reports assessed using ecological momentary assessments (EMA) among racially diverse, community dwelling older adults. Participants were from the Einstein Aging Study (N=311, age=70-91) and completed a 14-day EMA protocol which included self-reports of pain intensity 6 times a day. Pain IIV was quantified using intraindividual standard deviation (iSD). We followed Wang and Grimm (2012)’s approach to calculate the reliability of IIM and IIV. Over a 2-week period, we found excellent reliabilities for both pain IIM (.99) and pain IIV (.91), showing that these measures are reliable and can be used to link with various health outcomes among community dwelling older adults. We also estimated the average number of assessments that produce acceptable levels of reliability. The average of 2 assessments for pain IIM and 23 assessments for pain IIV produced values that exceeded reliability score of .80, suggesting that a briefer study design may be used to reduce participants’ burden with reliable pain metrics. Future studies need to examine whether pain IIV is associated with cognitive, emotional, and physical health among older adults and whether intervention studies that target to reduce pain IIV improve health consequences.

SUPPORTING INNOVATIVE STRATEGIES TO REDUCE OPIOID-RELATED HARM AMONG OLDER ADULTS IN PRIMARY CARE
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Older adults are more likely to be prescribed opioids and to suffer from opioid-related harms. Despite growing concerns about opioid misuse in older adults, providers and health care systems often struggle with approaches that would effectively manage opioid use and reduce opioid misuse in older adults. To address this issue, the Agency for Healthcare Research and Quality funded a four-year project to work with primary care practices in developing and testing innovative strategies for opioid management in older adults. To develop a change package that will inform learning collaboratives where primary care practices will be encouraged to test new or modified strategies in managing opioids in older adults, Abt, the contractor, first completed an environmental scan to identify existing resources/tools. Identified resources/tools were vetted by an expert panel and appropriate items were used to develop a change package consisting of nine high-leverage change (HLC) strategies (e.g., Develop processes/workflows that clearly define roles/responsibilities and promote coordinated team-based care). In the change package, multiple key activities that accompany each HLC strategy are presented as examples of strategies that could be implemented to bring about the selected HLC. Primary care practices participating in learning collaboratives will use the change package to guide the development and testing of strategies to manage opioids in their older adults, which will inform the development and refining of a compendium of strategies to best reduce harms of opioid use in older adults.