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Head and neck cancer (HNC) accounts for 4% of all cancers diagnosed in the US, with 75% in adults over 55 years of age. HNC survivors must deal with the long-term consequences of the cancer and its treatments, which can have significant long-term physical, psychosocial, and financial consequences, dramatically impacting survivors' lives. While research has identified the unmet needs of HNC survivors, there has been little examination of HNC survivors' experiences living with a cancer history and engaging in survivorship care. To explore survivors' experiences and their attitudes toward their survivorship care, we conducted in-depth, semi-structured interviews with 22 HNC survivors whose survivorship care was managed within the HNC program of an academic tertiary care institution. Participants' mean age was 65 years old, ranging from 33 to 86. The majority of the participants were male (68%), white (96%), married (81%), and had some college education or a higher degree (81%). One third of participants (n=7) had rural residence, as defined by the Rural-Urban Continuum Codes. Participants reported a wide range of experiences based on multiple factors: cancer site, staging, and treatment; their expectations prior to treatment; and personal and social context. They varied in their approaches toward understanding and incorporating the impacts of their cancer experience, from physical side effects of treatment to social impacts. They described the importance of survivorship care both in physical and social terms. We discuss the implications of these results for future interventions to improve HNC survivorship care delivery.

IS PAIN TIME PATTERN PREDICTIVE OF FUTURE TIME PERSPECTIVE IN OLDER CHRONIC PAIN PATIENTS?

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Chronic pain patients constitute 65% of those ages 65 and older in the US. Many affected older adults are challenged to manage physical and psychological consequences tied to the intensity, interference, and temporal pattern of their pain. However, little quantitative research highlights the psychological impact of constant versus intermittent or ever-present-yet-variable pain, even though temporal pain pattern may have meaningful predictive power for wellbeing and future time perspective (FTP). A positive and expansive view of the future is particularly adaptive for this population because it is positively associated with treatment adherence. In this study, we analyzed secondary data to determine whether pain temporal pattern and pain duration are associated with differences in participant scores on Carstensen & Lang's Future Time Perspective scale. All participants (N=142) were 45 years old and older with non-cancer chronic pain lasting three months or more. There was no significant association between pain time pattern and FTP ($p=.35$). Additionally,

controlling for pain duration, average FTP scores did not vary significantly as a function of time pattern ($p=.07$). Our analyses demonstrated no significant relationship between pain time pattern and FTP and no significant moderating effect of pain duration. However, in contrast to the previous literature, FTP was not significantly associated with age and negatively (rather than positively) associated with subjective health ($r=-.08$, $p=.35$; $r=-.24$, $p<.01$), thus raising concerns about the generalizability of these findings. Implications for understanding time perceptions in older pain patients are discussed.

LONGITUDINAL CHANGES IN ARTHRITIS PAIN CONTRIBUTE TO SUBSEQUENT CHANGES IN BODY MASS

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Prior studies have documented that body mass index (BMI) is positively associated with bodily pain. However, data on the temporal sequence of BMI and pain suggest mixed results, with some studies indicating a bi-directional relationship, and other research among older adults supporting a uni-directional relationship from BMI to increased pain. Thus, it is critical to further examine temporal dynamics between changes in BMI and changes in bodily pain to help explicate possible mechanisms influencing the relationship. This study evaluated bivariate dynamic models of longitudinal change (McArdle & Hamagami, 2003) in the relationship between BMI and bodily pain with data from older adults participating in the Swedish Adoption/Twin Study of Aging (SATSA). The sample included 858 individuals aged 45-88 at intake, with up to eight waves of follow-up over 26 years. BMI $\{weight(kg)/[height(m)]^2\}$ was evaluated with objective measures of weight and height recorded by a study nurse. Pain symptoms were measured with six self-report pain questions, reflecting two pain factors: (1) pain in neck, back, or shoulder; and (2) hip pain, history of arthritis, or use of arthritis medications. Results indicated that the relationship between BMI and arthritis pain was uni-directional, with changes in pain symptoms contributing to subsequent changes in BMI, but no evidence that changes in BMI contributed to subsequent changes in pain symptoms. Model comparison indicated that the impact of pain on BMI was greatest before age 70, and then reduced somewhat after age 70, when the impact of other factors on BMI (e.g., ill health) likely increases.

MEDICATION MANAGEMENT AMONG OLDER ADULTS WITH MULTIPLE CHRONIC CONDITIONS: WHAT ROLE DO CAREGIVERS PLAY?

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Many older adults manage multiple chronic conditions (MCC) that require adherence to complex medication regimens. Few studies have investigated the degree to which caregivers support medication-related behaviors. We conducted semi-structured qualitative interviews with 25 caregivers

of older adults with MCC to characterize caregiver medication assistance. Two coders used content and constant comparative analysis to analyze transcripts. The mean age of caregivers was 61 years; the majority were female (68%) and identified as non-white (Black, 52%; Hispanic, 8%). Caregivers were predominantly spouses ($n=10$), or children ($n=11$). Older adults were on average 73 years old, managing 5 chronic conditions and prescribed 7 medications. Caregivers acknowledged the importance of medications to the older adult's health, but their involvement in daily medication management was limited. Some caregivers preferred that the older adult continue these tasks to maintain autonomy, especially when caring for older adults who valued maintaining independence. Caregivers assumed medication responsibilities after older adults experienced sudden changes in health or upon observing non-adherence (e.g. full pill bottles). Older adults with higher medication burden (12+ medicines) adopted inefficient, cumbersome medication management practices; caregivers suggested simplified strategies, but the older adults refused to adopt recommended strategies. To combat resistance from the older adult, caregivers disguised assistance and deployed workaround strategies to monitor medication-taking behaviors. These findings suggest older adults and caregivers share a value of promoting independence of medication management, up until safety is seriously questioned. Additionally, there is a breakdown in communication at the time when older adults may benefit from increased caregiver involvement.

PAIN ACCEPTANCE PREDICTS EXPANSIVE OUTLOOKS ON THE FUTURE IN OLDER CHRONIC PAIN PATIENTS

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As chronic conditions continue to rise in the US, associated pain symptoms are rising as well, affecting 65% of those 65 and older. In an attempt to help patients lessen the burdensome physical/psychological effects of chronic pain, researchers have investigated the effectiveness of therapeutic interventions with pain acceptance-based models yielding the most promising effect sizes. However, these interventions do not explicitly account for how patients perceive their future. Qualitative work has shown that chronic pain patients with positive and expansive views of their futures report fewer pain-related anxiety and depression symptoms, and are more likely to engage in long-term (and often more effective) treatment regimens. This study aims to investigate whether pain acceptance scores predict future time perspective to enhance treatment effects of chronic pain interventions. Multivariate linear regression analyses were conducted with a sample of 148 non-cancer patients age 45 and older with chronic pain, i.e. pain lasting three or more months. Pain duration, neuroticism, sex, race, income, and age were included in the model to explore potential mediating or moderating effects. A significant positive association was found between pain acceptance and future time perspective ($r=.42$, $p<.001$, $r^2=.17$).

Additionally, with the inclusion of all covariates, our model significantly explained 24.1% of the variance in future time perspective in the sample, $F(7,132)=5.99$, $p<.001$. With an established association between these two psychological constructs, strategies to bolster future time perspective can easily be integrated into pain acceptance interventions for older chronic pain patients, hopefully pushing effect sizes past the 'moderate' level.

PATIENT EXPERIENCE OF AN OSTEOPOROSIS TELEMEDICINE CLINIC

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Rural Veterans at risk of fracture due to osteoporosis remain underdiagnosed and undertreated, in part due to location-related barriers to accessing care. Despite lowered cost and travel barriers to osteoporosis care through implementation of a telehealth model directed at rural at-risk Veterans that took advantage of many strengths of the VA's healthcare system, only 30% of eligible Veterans accepted care. To understand low acceptance, we conducted 39 semi-structured telephone interviews with Veterans eligible for the clinic, including 19 who accepted screening and treatment, 12 who completed screening but declined treatment, and 8 who declined screening and treatment. Veterans who opted to be screened and/or treated for osteoporosis did so because: it was recommended by the VA; they were interested in learning more about their health; thought they may be at risk of osteoporosis; or believed screening would not cause them harm. Conversely, Veterans refused screening or treatment because of past negative experiences with medications, both bone and non-bone; a wish to not put anything else into their bodies; or the belief that their bone loss is not severe enough to warrant treatment. Outside medical professionals and peers influenced Veterans' decisions to not take or alter their treatment. Cost and travel distance remained a barrier for Veterans who did not live near a VA facility with the necessary screening and treatment infrastructure. Many barriers to osteoporosis care remain despite efforts to remove them. Delivery systems must account for both instrumental and social access to care to reduce fracture risk.

THE EVALUATION OF A MODIFIED DECISION AID FOR OLDER WOMEN WITH LOW HEALTH LITERACY

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Given the lack of evidence recommending mammography for women >75 years, guidelines recommend that older women be informed of the uncertainty of benefits and of potential harms. The objective for this study was to evaluate the effect of a mammography decision aid (DA) designed for older women with low health literacy (LHL) on their decisional conflict and knowledge of mammography's benefits and