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 regiments. 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, r2=.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