less engagement in health behaviors. Implications of these findings will be discussed.

WHAT IS THE RELATIONSHIP BETWEEN FUNCTIONAL LIMITATIONS, PAIN, AND SELF-PERCEPTIONS OF AGING?

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Self-perceptions of aging (SPA) influences health and mortality during older adulthood (e.g., Kotter-Grühn et al., 2009; Sargent-Cox et al., 2012). Westerhof and Wurm (2015) found that increasing functional limitations (FL) worsened older adults' SPA. Additional research is needed to identify other factors that influence SPA. Although pain is common among older adults and is a frequent cause of disability (e.g., Brooks et al., 2019), it has not been examined as a factor influencing SPA. Pain is often misperceived as an inevitable part of aging because of widely held negative stereotypes about aging (Thielke et al., 2012). The experience of pain may activate internalized negative stereotypes about aging, which may worsen SPA. Thus, this study investigated: 1) the relationship between chronic and recent pain, FL, and SPA, and 2) the interactive effect of FL and pain on SPA within a sample of community-dwelling adults aged 65 years and older. This study included 5,126 participants from the 2014 wave of the Health and Retirement Study. Controlling for covariates, chronic pain ($\beta = .09$, $p < .001$) and recent pain ($\beta = .12$, $p < .001$) were associated with negative SPA and were stronger than FL ($\beta = .04$, $p < .01$). There was also a small interaction between FL and recent pain on SPA ($\beta = -.03$, $p < .01$) such that the negative impact of FL on SPA was stronger among individuals who reported low pain. These findings highlight the importance of pain in older adults' evaluation of their own aging.

Session 9025 (Poster)

Aging and Chronic Health Conditions I

BLOOD PRESSURE CONTROL AND CARDIOVASCULAR AND MORTALITY RISK IN VA NURSING HOME RESIDENTS

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Optimal blood pressure (BP) control in nursing home residents is controversial and this population has been excluded from trials. We evaluated the associations of BP level with cardiovascular (CV) events and all-cause mortality across antihypertensive medication categories in Veterans Affairs (VA) nursing home residents. Data for 18,589 residents aged 65 years and older was obtained from the VA Corporate Data Warehouse from October 2006 through September 2017. Baseline systolic BP (SBP) and diastolic BP (DBP) were divided into categories and analyses were stratified by antihypertensive therapy (0, 1, and ≥2 medications). Over a median follow-up of 1.8 years, CV events occurred in 3,519 (19%) residents and 15,897 (86%) residents died. In participants on no BP medications, high SBP (>150 mmHg) was associated with a greater risk of CV events (adjusted [cause-specific] hazard ratio, 1.39; 95% confidence interval, 0.94-2.06) compared with normal SBP (110-130mmHg). By contrast, in participants on ≥2 BP medications, the subgroup with low SBP (<110 mmHg) had a higher CV risk (1.38; 1.20-1.57). For DBP, in participants without BP medications, there were no differences in CV risk across DBP subgroups. Whereas among those on 1 or ≥2 medications, DBP <60 mmHg was associated with a higher CV risk (1.26; 1.03-1.55 and 1.35; 1.18-1.54, respectively) compared with normal DBP (70-80 mmHg). Participants with low SBP (<110 mmHg) and DBP (<70 mmHg) had an increased mortality risk regardless of the number of medications. These findings suggest a potential risk of low BP among nursing home residents on multiple antihypertensive medications.

BONE-ACTIVE MEDICATION UTILIZATION FROM 2013-2017 AMID BENEFICIARIES AGED 65+ WITH MEDICARE PART D BY PROVIDER TYPE

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As the United States' population increasingly consists of older adults aged 65+, an increase is expected in the prevalence of osteoporosis and the number of osteoporotic fractures. Bone-active medications (BAM) delay osteoporosis progression and prevent fragility fractures, but historically low treatment persistence rates and drug utilization for BAM exist among at-risk older adults. This research assessed for differences in the BAM utilization rates over five-years in Medicare Part D by provider type: geriatric specialists (GERO), generalists, specialists, nurse practitioners (NP), and physicians' assistants (PA). This longitudinal retrospective analysis included providers with at least one BAM prescription among beneficiaries aged 65+. An analysis of response profiles was used to model the mean BAM utilization rates overall and by provider group. Of the 50,249 providers included in this analysis, 88.15% were generalists, 5.76% specialists, 1.48% GERO, 2.73% NP, and 1.87% PA. From 2013-2017, the prevalence of BAM utilization was 6%. Over the five years, BAM utilization rates did not change significantly, but provider-specific rates were significantly different (F=12.53, p<.001). Provider-specific utilization rates were inconsistent with the highest utilization rates and most considerable variation observed among specialists (14.95%). PAs and NPs' BAM utilization rates were stable at around 9.02% and 9.20%, but GERO and generalists exhibited the lowest utilization rates, 4.86% and 5.79%, respectively. While specialists had the higher-than-expected utilization rates, the overall and provider-specific BAM utilization rates were low and did not increase over time. Further research is needed to identify how provider-related factors, like geographic region and clinical training, influence underutilization.