

G. Choi, PhD, FGSA, of the University of Texas at Austin. The Maxwell A. Pollack Award for Contributions to Healthy Aging Award recognizes instances of practice informed by research and analysis, research that has directly improved policy or practice, and distinction in bridging the worlds of research and practice.

MAXWELL A. POLLACK AWARD LECTURE

Karl Pillemer, *Cornell University, Ithaca, New York, United States*

The lecture will feature an address by the 2020 Pollack Award recipient, Karl Pillemer, PhD, FGSA of Cornell University. The 2021 Pollack Award recipient is Namkee G. Choi, PhD, FGSA, of the University of Texas at Austin. The Maxwell A. Pollack Award for Contributions to Healthy Aging Award recognizes instances of practice informed by research and analysis, research that has directly improved policy or practice, and distinction in bridging the worlds of research and practice.

Session 3285 (Paper)

Medications and Prescribing

DEPRESCRIBING BLOOD PRESSURE TREATMENT IN VA LONG-TERM CARE RESIDENTS

Michelle Odden,¹ Sei Lee,² Michael Steinman,² Anna Rubinsky,³ Bocheng Jing,⁴ Kathy Fung,⁴ Laura Graham,⁵ and Carmen Peralta,³ *1. Stanford University, Stanford, California, United States, 2. University of California San Francisco, San Francisco, California, United States, 3. University of California, San Francisco, San Francisco, California, United States, 4. San Francisco VA Medical Center, San Francisco, California, United States, 5. VA Palo Alto Health Care System, Menlo Park, California, United States*

There is growing interest in deprescribing of antihypertensive medications in response to adverse effects, or when a patient's situation evolves such that the benefits are outweighed by the harms. We conducted a retrospective cohort study to evaluate the incidence and predictors of deprescribing of antihypertensive medication among VA long-term care residents ≥ 65 years admitted between 2006 and 2017. Data were extracted from the VA electronic health record, CMS Minimum Data Set, and Bar Code Medication Administration. Deprescribing was defined as a reduction in the number of antihypertensive medications, sustained for 2 weeks. Potentially triggering events for deprescribing included low blood pressure ($<90/60$ mmHg), acute renal impairment (creatinine increase of 50%), electrolyte imbalance (potassium below 3.5 mEq/L, sodium decrease by 5 mEq/L), and fall in the past 30 days. Among 22,826 VA nursing home residents on antihypertensive medication, 57% had describing event during their stay (median length of stay = 6 months). Deprescribing events were most common in the first 4 weeks after admission and the last 4 weeks of life. Among potentially triggering events, acute renal impairment was associated with greatest increase in the likelihood of deprescribing over the subsequent 4 weeks: among residents with this event, 32.7% were described compared to

7.3% in those without (risk difference = 25.5%, $p < 0.001$). Falls were associated with the smallest increased risk of deprescribing (risk difference = 2.1%, $p < 0.001$) of the events considered. Deprescribing of antihypertensive medications is common among VA nursing home residents, especially after a potential renal adverse event.

OPIOID USE AMONG RURAL MEDICARE BENEFICIARIES

Yvonne Catharina Jonk,¹ Heidi O'Connor,² Karen Pearson,³ Zachariah Croll,² and John Gale,³ *1. University of Southern Maine, Muskie School, Portland, Maine, United States, 2. University of Southern Maine, Portland, Maine, United States, 3. University Of Southern Maine, Portland, Maine, United States*

This study examines differences in opioid prescribing rates among a nationally representative sample of Medicare beneficiaries across rural and urban areas, as well as among beneficiaries with chronic overlapping pain conditions (COPCs). We assess whether prescribing patterns exceed the Centers for Disease Control and Prevention guidelines for dose and duration, and identify socioeconomic and health risk factors associated with opioid prescribing using logistic regression analyses. Data were from the 2010-2017 Medicare Current Beneficiary Survey files. Rural-Urban Commuting Area codes were used to identify patients' residential location. The Area Health Resource Files were used to identify market characteristics such as primary care and mental health shortage areas. With the exception of 2010, over years 2011-2017, higher percentages of community-dwelling rural beneficiaries received opioid prescriptions (21.8-25.4%) compared to their urban counterparts (19.1-23.7%). During the same time period, facility-dwelling rural beneficiaries were more likely to receive opioid prescriptions (39.8-47.2%) compared to their urban counterparts (28.8-35.0%). Higher percentages (18.8%) of the community dwelling population in rural had COPCs compared to urban (15.2%), and a higher percentage of rural beneficiaries with COPCs (31.4%) received an opioid prescription than their urban counterparts (22.2%). Previous research points to other factors contributing to a lack of alternatives to opioids for pain management in rural areas, including greater reliance on primary care providers, lack of access to chronic pain specialists and alternative therapies, and travel barriers. Improving the capacity of rural primary care to deal with COPCs and expanding access to specialists via telehealth warrants further attention from policymakers.

PHARMACIST-LED INTERVENTIONS TO IMPROVE MEDICATION ADHERENCE IN OLDER ADULTS: A META-ANALYSIS

Zachary Marcum,¹ Shangqing Jiang,¹ Jennifer Bacci,¹ and Todd Ruppert,² *1. University of Washington, Seattle, Washington, United States, 2. Rush University College of Nursing, Chicago, Illinois, United States*

As pharmacists work to ensure reimbursement for chronic disease management services on the national (e.g., Medicare) level, summative evidence of their impact on important health metrics, such as medication adherence, is needed. The objective of this study was to assess the effectiveness of pharmacist-led interventions on medication adherence