the weekly prevalence of SSI among 22,847 veterans with diabetes admitted to VA nursing homes (NHs). Average age was 75.3 (SD 8.3) years, mean A1c was 7.3% (SD 1.6%) and 57% were admitted from hospital. We first identified residents receiving any short-acting insulin. We then classified short-acting insulin use into three mutually exclusive regimens: (1) fixed scheduled doses, (2) SSI, defined as a variable dose of short-acting insulin without a concurrent fixed dose or (3) bolus with correction (BWC), defined as a variable dose given concurrently with a fixed dose that day. During the first week of NH admission, 64.7% of residents with diabetes received no short-acting insulin, 7.4% received fixed scheduled doses, 6.3% received BWC and 21.4% were on SSI. At week 12, the prevalence of fixed dose and BWC regimens was unchanged from baseline (fixed dose = 8.4%; BWC = 7.0%). In contrast, the prevalence of SSI decreased weekly to 15.8% (p for linear trend < 0.0001). Although SSI prevalence decreased from week 1 to week 12, 51% of residents on short-acting insulin were still using SSI in their 12th week of their NH stay.

ASSOCIATION BETWEEN PRESCRIPTION OPIOID USE AND MORTALITY IN COMMUNITY-DWELLING OLDER ADULTS

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Prescription opioid use is concerning among older adults. Yet, few studies have examined the impact of opioid use on mortality by considering multimorbidity. Our sample includes 1586 older adults aged ≥65 recruited in primary care from 2011-2013 in a large health administrative region in Quebec and participating in the ESA-Services study, a longitudinal study on aging and health service use. An opioid prescription delivered in the 3 years prior to the baseline interview was identified using the provincial pharmaceutical drug registry. Mortality was ascertained from the vital statistics registry until 2015. The presence of chronic diseases was based on self-reported and physician diagnostic codes in health administrative databases. Physical multimorbidity was defined as ≥3 chronic physical conditions from either source. Physical/psychiatric multimorbidity was defined as ≥3 chronic physical conditions and ≥1 common mental disorder from either source. Logistic regression analyses were conducted to examine the association between opioid use and mortality, controlling for sociodemographic factors. Interactions were tested for opioid use and multimorbidity. Older adults with physical multimorbidity using opioids were 1.76 (95%CI: 1.02-3.03) times more likely to die than those not using opioids. Those with physical/psychiatric multimorbidity using opioids were 2.27 (95%CI: 1.26-4.09) times more likely to die than those not using opioids. Older age, male sex, and single marital status significantly increased the risk of mortality. Overall, opioid use increases the risk of death in older adults with multimorbidity. The presence of mental disorders further increases the risk of death in older adults with physical multimorbidity using opioids.

CAREGIVERS' PERSPECTIVES OF MEDICATION MANAGEMENT ADVICE FOR PEOPLE WITH DEMENTIA AT HOSPITAL DISCHARGE

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People with dementia admitted to hospitals are more likely to be exposed to inappropriate polypharmacy and experience worse outcomes than people without dementia. Family and informal caregivers play an important role in managing medications across transitions of care; however, studies describing the experiences of medication guidance provided to caregivers at hospital discharge are limited. We have explored caregivers' perceptions on the quality of and factors that influence caregiver participation in medication guidance at discharge. A qualitative approach using semi-structured interviews was conducted with 29 caregivers of people with dementia across Australia by telephone. Purposive sampling was used to ensure maximum variation of diverse perspectives. Content analysis was used to derive themes. Three themes were derived from analysis: inconsistent approaches to provision of medication information at discharge, caregiver awareness to advocate for the care recipient and managing competing priorities. Some caregivers reported inadequate information was provided because the information was communicated to the patient without the caregiver being present. Other caregivers stated a medication list, discharge summary and discussion with a healthcare profession provided useful information. Caregiver involvement in discussions on medication guidance at discharge was influenced by caregiver awareness to advocate for the care recipient to ensure medication safety and managing competing priorities at the time of discharge to manage stress. Caregivers flagged the need to establish structured caregiver education at discharge and community-based services to manage medications safely. Future studies are needed to explore development of resources to caregiver encourage participation during medication guidance at discharge.

EVALUATION OF A COLLABORATIVE CARE MANAGEMENT PROGRAM FOR COMMUNITY-DWELLING OLDER ADULTS ON HIGH-DOSE OPIATES

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Treating pain in later life is complex, and there are significant safety risks associated with the use of analgesics, particularly opioids. This study examined preliminary results from a pilot study of a telephone-delivered collaborative care service designed for community-dwelling older adults with chronic pain receiving prescriptions for high doses of opioids