refusal of VTE prophylaxis doses is the most common documented reason for a vast majority of refused doses. We have initiated a mixed-methods investigation to determine what patient, nursing unit, and culture of care-level factors may explain refusal of these doses.

**PCV69**

**IMPACT OF COMMUNITY PHARMACIST-LED COUNSELING ON IMPROVING MEDICATION ADHERENCE**

**OBJECTIVES:** To assess the impact of pharmacist-led face-to-face counseling on prescription first refill rate in patients who are new to statins or thyroid medications.

**METHODS:** A retrospective pre-post with case-control cohort study design was employed. In May 2010, two community pharmacies implemented face-to-face counseling-trained pharmacist visits at the site of care when patients initially filled their statin or thyroid prescriptions. Patients’ first refill rate, defined as percentage of patients who refilled their prescriptions within a two-week’s period after exhaustion of their initial fill, was assessed as the primary outcome measure. Similar computations were performed for patients who filled their prescriptions at the two stores, 12-months prior to the intervention program. Additionally, two control pharmacy stores were selected based on pharmacy type, operational years of stores, prescription volume, and corresponding population characteristics. Refill rates in the pre and post-periods were also computed for control stores. A chi-square test was performed to investigate the relationship between face-to-face intervention and patients’ first refill rate.

**RESULTS:** Test stores that implemented face-to-face counseling, conducted interventions on 81 new to therapy patients in the pre-period, while a total of 92 (new to therapy patients) were included in the pre-period. A total of 73 and 81 new to therapy patients were selected from control stores in the pre and post-period respectively. For test stores, chi-square analyses showed a significant increase in the refill rates in the post-period compared to the pre-period (BIPQ 55.7% Vs Post-period 61.7%, p < 0.05). **CONCLUSIONS:** Pharmacist-led face-to-face counseling had a positive impact on patient’s refill behavior. The study showed an early impact of the program; additional larger pilot studies and longer follow-up period are needed to better understand the full benefit of the program.

**PCV70**

**VARIATIONS IN THE IMPACT OF ILLNESS PERCEPTIONS AND MEDICATION BELIEFS ON MEDICATION COMPLIANCE OF ELDERLY VersUS GERIATRIC HYPERTENSIVE PATIENTS: A COMPARATIVE ANALYSIS**

**OBJECTIVES:** To measure and compare the extent of medication compliance in elderly and geriatric hypertensive cohorts. To evaluate the role of illness perceptions and investigation of how medication beliefs and dimensions of illness perceptions, might impact medication compliance outcome in hypertension. **METHODS:** A cross-sectional research design, utilizing convenience sampling strategies and self-administered versions of elderly hypertension residents living in New York City senior care centers (N=117). Medication compliance was measured using Morisky’s test; medication beliefs were measured using Beliefs about Medication Questionnaire (BMQ), and illness perceptions using Brief Illness Perceptions Questionnaire (BIPQ). The study population comprised of the population was white (75%). The study showed no significant differences observed demographically between the elderly (55-65 years) and geriatric (65+ years) samples except with respect to college education (53% vs. 47%). About 46% of the elderly sample was noncompliant with hypertension medications, compared to 63% who were 65 years and older (geriatric). BMQ-component scores correlated positively with medication compliance score across both elderly and geriatric samples (p < 0.134, p < 0.496 and r = 0.447, p = 0.000, respectively). The score on Specific Necessity Beliefs dimension associated positively with Morisky’s Test score across both the cohorts (r = 0.207, p < 0.052 and r = 0.297, p < 0.020), whereas General Harm and General Overuse Beliefs about medication correlated negatively with medication compliance. A majority of the participants rank-ordered stress as the number one cause of their illness (49.1%), followed by ‘lifestyle’ (43.8%) and ‘hereditary factors’ (7.1%). **CONCLUSIONS:** Medication noncompliance seems to worsen with an increase in age. Stronger necessity beliefs and more geriatric (65+ years) and moderate and high-risk patients were compared with low and moderate-risk patients, adjusting for sociodemographic and health characteristics using logistic regression models. Among 1,350 respondents diagnosed with AF (projected US prevalence of 1.49%), 308 (22.8%) were low, 473 (35%) moderate, and 569 (42.2%) high in risk of stroke. High- vs. low-risk patients were significantly more likely to take any preventative steps (60.5% vs. 34.1%, respectively; OR = 2.75, p < 0.0001). Furthermore, high-risk patients were significantly more likely to take steps to lower their blood pressure (OR = 0.33, p < 0.001), cholesterol (OR = 2.46, p < 0.007), use clopidogrel (OR = 0.27, p < 0.003) or other stroke prophylactic medications (OR = 3.32, p < 0.003) compared with low-risk patients. No differences were observed on lifestyle modification such as diet, exercise or smoking cessation. **CONCLUSIONS:** These results suggest, US adults at high risk of stroke are more likely to take steps to lower high blood pressure and cholesterol use medications to prevent stroke, compared to moderate-risk patients. No significant differences emerged on diet, regular exercise, smoking cessation and aspirin use. Higher risk correlated with higher prevention, yet there remains an unmet need for increased targeted treatment and lifestyle changes for high-risk AF patients.

**PCV73**

**CONSTRUCT VALIDITY OF HEALTH UTILITIES INDEX (HUI) JAPANESE VERSION: CROSS-SECTIONAL STUDY FOR STROKE IN JAPAN**

**OBJECTIVES:** To assess the measurement properties and validity of Health Utilities Index Mark 3 (HUI3) Japanese version for stroke patients in Japan. **METHODS:** The HUI3 was administered to 553 patients with stroke who were admitted in seven hospitals. Proxies of the patients completed Japanese version of the HUI3 questionnaires at start phase of rehabilitation. Patients were categorized using modified Rankin scale (MRS). The construct validity was assessed by analyzing the degree to which lower score on the HUI3 scores correlated positively with MRS. **RESULTS:** Mean global score was as follows: MRS 1 = 0.62 (SD = 0.22), MRS 2 = 0.48 (SD = 0.28), MRS 3 = 0.27 (SD = 0.24), MRS 4 = 0.00 (SD = 0.18), MRS 5 = 0.23 (SD = 0.13). Worst mean score was ambulation (H1) and, subsequently, vision and dexterity (0.65). **CONCLUSIONS:** Our results indicate the productive future for Japanese HUI3 use and showed precise measuring properties of the HUI3 Japanese version in assessing health status for stroke patients.