FRAILTY AND THE COMPARATIVE EFFECTIVENESS AND SAFETY OF SGLT2I AND DPP4I IN OLDER ADULTS WITH TYPE 2 DIABETES

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We conducted a 1:1 propensity score-matched retrospective cohort study of 83,432 patients with type 2 diabetes (mean age, 71.5 years [standard deviation, 5.0]) initiating a SGLT2i or a DPP4i in Medicare data. We estimated HRs (95% CIs) for a composite cardiovascular endpoint and severe hypoglycemia comparing the two treatments in the entire population and by the CFI-based frailty subgroups. Compared with DPP4i, SGLT2i were associated with a lower rate of the composite cardiovascular endpoint (HR, 0.70 [95% CI, 0.64-0.77]) and a similar rate of severe hypoglycemia (0.88 [0.71-1.07]) over a mean follow-up of 8.8 months. The rate of composite cardiovascular endpoint for SGLT2i vs DPP4i was consistently lower in pre-frail (0.71 [0.64-0.79]) and frail (0.67 [0.55-0.80]) subjects, but not in non-frail patients (0.98 [0.62-1.54]). The rate of severe hypoglycemia was not meaningfully different between SGLT2i and DPP4i (non-frail, 0.39 [0.12-1.16]; pre-frail, 0.83 [0.65-1.07]; frail, 1.13 [0.78-1.64]).

FRAILTY AND THE COMPARATIVE EFFECTIVENESS AND SAFETY OF SGLT2I AND GLP1-RA IN OLDER ADULTS WITH TYPE 2 DIABETES

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We conducted a 1:1 propensity score-matched retrospective cohort study of 87,218 patients with type 2 diabetes (mean age, 71.5 years [standard deviation, 5.1]) initiating a SGLT2i or a GLP1-RA in Medicare data. We estimated HRs (95% CIs) for a composite cardiovascular endpoint and severe hypoglycemia comparing the two treatments in the entire population and by the CFI-based frailty subgroups. Compared with GLP1-RA, SGLT2i were associated with similar rates of the composite cardiovascular endpoint (HR, 0.94 [95% CI, 0.86-1.03]) and severe hypoglycemia (0.87 [0.71-1.07]) over a mean follow-up of 8.6 months. The rate of composite cardiovascular endpoint was not meaningfully different between SGLT2i and GLP1-RA across non-frail (1.33 [0.80-2.23]), pre-frail (0.96 [0.85-1.08]), and frail patients (0.87 [0.73-1.04]). Similarly, the rate of severe hypoglycemia was not meaningfully different between the two treatments among non-frail (0.97 [0.20-4.80]), pre-frail (0.83 [0.64-1.08]), and frail patients (0.95 [0.67-1.34]).

SESSION 3060 (SYMPOSIUM)

GETTING TO YES . . . I WILL RESPOND: CHALLENGES AND SUCCESSES SURVEYING AGING SERVICES PROVIDERS TO PRODUCE QUALITY DATA

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Voluntary surveys of aging services providers are important data sources for research, quality improvement, and program evaluation efforts to inform evidence-based decision making. Ideally, provider surveys—a type of establishment survey—offer valuable information on providers and services users. However, decreasing survey response rates in recent years raise data quality concerns. This symposium highlights challenges leading to lower response rates (e.g., time constraints, skepticism, confidentiality concerns, getting to the correct respondent); specific data collection techniques tested, what did and did not work, and lessons learned. Although the surveys focus on long-term services and supports (LTSS) providers (e.g., assisted living) and services users (e.g., residents), the session is generalizable to other establishment surveys. Presenters bring extensive survey experience and diverse organizational perspectives—academic research center, national provider association, federal statistical agency, and research contractor. Over the years, the presenters have used their research network to share challenges and lessons learned with each other, which addresses the GSA conference theme, "Strength in Age: Harnessing the Power of Networks." The first presentation describes test results of a state survey protocol to obtain sampled resident information from assisted living providers. The second presentation examines approaches to increase provider participation in a quality improvement initiative. The third presentation discusses efforts to address response challenges in an on-going national survey of providers in two LTSS sectors. The session allows time for and facilitates interaction with audience members to share their insights and lessons learned.

COLLECTING RESIDENT DATA FROM RESIDENTIAL CARE COMMUNITIES USING MAIL QUESTIONNAIRES: A NEW APPROACH

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Researchers who collect resident-level data from RCCs face several challenges. Conducting face-to-face, on-site interviews with administrators is costly and presents scheduling difficulties. Contacting administrators by telephone requires multiple attempts. Even when they are reached, they have limited time and might not share resident-level data. To overcome these difficulties, the current survey of Oregon RCCs combines a mail questionnaire with a self-administered sampling tool that allowed communities to select a random sample of their residents (two from each community). Pilot interviews with administrators indicated they were able to select a random sample of their residents easily, quickly, and accurately using this method. The feasibility and validity of this method were further tested by comparing results to community-level aggregate data collected using traditional mail questionnaires from RCCs (n=392). The similarities and differences between resident- and community-level data are discussed within the context of sampling design and mode of data collection from RCCs.

LESSONS LEARNED FROM QUALITY IMPROVEMENT DATA COLLECTION FROM ASSISTED LIVING PROVIDERS

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