PILOTING THE MONEY SMART FINANCIAL LITERACY PROGRAM IN JAMAICA

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This paper describes the piloting of a culturally modified version of the FDIC Money Smart Peer-to-Peer Program. The pilot study examined the use of Mentorship Teams comprised of two persons one (60 years and over) and another (30 - 59 years) who collectively provided mentorship and financial education to four working-age adults. The pilot was designed with four (4) phases: Phase 1 included recruitment and training of Mentors, Phase 2 the assignment of Mentors and Mentees, Phase 3 application of the intervention, and Phase 4 the evaluation of outcomes. This paper will review the design and recruitment processes, modifications made to the existing Money Smart Peer-to-Peer Program for cultural sensitivity and financial system factors, implementation challenges (including barriers and facilitators) and lessons derived from initiation and program implementation.

SESSION 3050 (SYMPOSIUM)

FRAILTY AND THE EFFECTIVENESS AND SAFETY OF NEW GLUCOSE-LOWERING DRUGS IN OLDER ADULTS WITH TYPE 2 DIABETES

Chair: Dae H. Kim, *Hebrew SeniorLife, Boston, Massachusetts, United States*
Co-Chair: Elisabetta Patorno, *Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts, United States*
Discussant: Medha Munshi, *Beth Israel Deaconess Medical Center, Boston, Massachusetts, United States*

Recently, several classes of non-insulin glucose-lowering drugs, such as dipeptidyl peptidase-4 inhibitors (DPP4i), glucagon-like peptide-1 receptor agonists (GLP1-RA), and sodium glucose co-transporter-2 inhibitors (SGLT2i), have been approved to treat type 2 diabetes. Clinical trials have shown that GLP1RA and SGLT2i confer cardiovascular benefit, while DPP4i do not have such benefit; these drugs do not seem to increase the risk of hypoglycemia. However, due to underrepresentation of older adults with frailty and lack of frailty assessment in clinical trials, little is known about how the effectiveness and safety of these drugs change across different levels of frailty. In this symposium, we present the real-world evidence from Medicare data April 2013-December 2016 on the utilization trends of newly approved diabetes drugs (Dr. Dave) and comparative effectiveness and safety of SGLT2i vs sulfonylurea (Dr. Pawar), SGLT2i vs DPP4i (Dr. Kim), and SGLT2i vs GLP1-RA (Dr. Patorno). The outcomes were 1) composite cardiovascular endpoint of mortality, myocardial infarction, stroke, or heart failure; and 2) severe hypoglycemia, defined as emergency department visits or hospitalizations due to hypoglycemia. We applied a validated claims-based frailty index (CFI) to estimate the treatment effectiveness and safety in non-frail (CFI<0.10), pre-frail (CFI 0.10-0.19), or frail individuals (CFI≥0.20). Following individual presentations, Dr. Munshi and presenters will lead an interactive discussion about clinical implications and methodological challenges in conducting geriatric pharmacoepidemiologic studies using Medicare data. This symposium will demonstrate the utility of CFI in claims-based pharmacoepidemiologic studies and provide health care providers with new evidence to tailor diabetes pharmacotherapy based on frailty.

UTILIZATION TRENDS OF NEWLY APPROVED GLUCOSE-LOWERING DRUGS FOR TYPE 2 DIABETES

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Using Medicare fee-for-service data from 2013-2015, we identified 3.2 million patients per year (mean [SD] age, 74.7 years [standard deviation, 7.2]) who were treated with glucose-lowering drugs for type 2 diabetes. Between 2013 and 2015, the proportion of patients treated with sulfonylureas declined from 27.4% to 25.1%; those using DPP4is (11.5% to 12.0%) and GLP1-RAs (1.8% to 2.4%) remained unchanged; those using SGLT2is increased from 0.2% to 1.9%. In the subgroup of patients initiating a glucose-lowering drug without prior use of the same class agent, the proportion of patients starting sulfonylureas (18.7% to 17.2% of initiators), DPP4is (16.0% to 15.0% of initiators), and GLP1-RAs (3.4% to 4.2% of initiators) changed little between 2013 and 2015, while those starting SGLT2is increased from 0.7% to 6.5% of initiators. In the Medicare population, we observed a persistently high use of sulfonylureas and a rapid uptake of SGLT2is among the newer classes.

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

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We conducted a 1:1 propensity score-matched retrospective cohort study of 70,826 patients with type 2 diabetes (mean age, 71.4 years [standard deviation, 5.0]) initiating a SGLT2i or a second-generation sulfonylurea 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 sulfonylureas, SGLT2is were associated with lower rates of the composite cardiovascular endpoint (HR, 0.68 [95% CI, 0.62-0.75]) and severe hypoglycemia (0.43 [0.35-0.53]) over a mean follow-up of 9.5 months. The lower rate of composite cardiovascular endpoint for SGLT2i vs sulfonylureas was observed in pre-frail (0.68 [0.61-0.77]) and frail (0.64 [0.53-0.77]) subgroups, but not in non-frail subgroup (0.95 [0.59-1.54]). The rate of severe hypoglycemia was consistently lower for SGLT2i vs sulfonylureas across frailty subgroups (non-frail, 0.37 [0.12-1.16]; pre-frail, 0.45 [0.35-0.59]; frail, 0.40 [0.28-0.58]).