

Prescription records from the first prescription post-ACS event till the end of follow-up were used. (Prot.No: 16_188R2). Adherence was observed for several exposure groups (aspirin only, clopidogrel only, aspirin-clopidogrel, aspirin-prasugrel, aspirin-ticagrelor) over various time intervals (from 30 to 1440 days post-ACS, between January 2007 and December 2015). Proportion of Days Covered (PDC) was the adherence measure, and a PDC value of 80% was adopted to classify patients as "adherent". **RESULTS:** Records for 21936 patients were obtained. Patients on antiplatelet monotherapy regimens followed similar adherence patterns, with PDC close to 90% until around 630 days from initiation, and then dropping, but remaining above 80% afterwards. Patients on dual antiplatelet therapy (DAPT) regimens were adherent for 12 months, with PDC dropping below 80% after 450 days in the aspirin-clopidogrel group and below 90% in the other two DAPT groups. Regimen adherence to all three DAPTs appeared to become similar after 630 days, at 65%. **CONCLUSIONS:** The study found good overall adherence to antiplatelet regimens in adults with T2DM. Adherence drop on DAPT regimens could be attributed to the fact that some patients might not need dual therapy for more than 12 months, and some time is needed to coordinate the switch from DAPT to antiplatelet monotherapy. Further investigation is needed to identify factors that affect antiplatelet adherence in this patient group.

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UTILIZING THE 3S FRAMEWORK TO UNDERSTAND THE PATIENT'S PREFERENCE WHEN ADDRESSING NON-ADHERENCE IN PATIENTS WITH DIABETES

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OBJECTIVES: Non-adherence with diabetes medicines is a challenge. Approximately 38% of patients on insulin and 64% on oral antidiabetics are non-adherent. The objective of this study was to understand the patient's preferences when addressing non-adherence based on the 3S framework – strategies (what approaches can be used in addressing non-adherence), settings (when and where should the intervention happen), and sources (who should provide the intervention). **METHODS:** A focus group research design was used among patients who were non-adherent with diabetes medicines from an integrated healthcare system in the US. The focus group guide was based on the Medication Adherence Reasons Scale that has nineteen specific reasons for non-adherence across the domains of forgetfulness, beliefs, logistics, and long-term concern issues. For each item in the scale, the patients were asked their experiences, strategies that can be used in addressing that issue, the setting in which the interventions should be provided, and the source from which the interventions should come from. Content analysis was used to analyze the data. **RESULTS:** Two focus group interviews, each group having seven patients, were conducted. The major strategies identified were patient education, self-responsibility of patients, family support, reminders, and societal support. The key educational needs were dealing with side effects and learning to use insulin properly, while utilizing different learning styles. For the setting, the patients preferred continuity of patient education throughout the disease journey. For the source, the physicians and pharmacists were considered key players who needed to have a continuous dialogue about the disease and medicines, and individuality in managing the disease. Respondents also recommended using a peer support group among patients. **CONCLUSIONS:** Patients with diabetes identified various preferred strategies for addressing the reasons for non-adherence. Educational strategies were identified as the foremost approach coming from physicians and pharmacists throughout their disease journey.

PDB66

SURVIVAL OF PATIENTS WITH DIABETES MELLITUS BY RESIDENTIAL AREA IN COLOMBIA, 2008-2017

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OBJECTIVES: To estimate the survival in a dynamic cohort of patients with diabetes mellitus (DM) affiliated to a public health insurer in Colombia. **METHODS:** Retrospective cohort study (2008 - 2017) of 29,286 patients diagnosed with DM affiliated to a public health insurer, grouped by residence area (urban and rural). Sociodemographic variables and mortality incidence were analyzed. Survival curves were estimated using Kaplan-Meier (KM), Log-Rank significance test and Cox regression models to identify risk factors mortality. **RESULTS:** The average annual mortality rate was 2.2 / 100persons-year [CI95% = 2.1-2.3]. In the fourth year of the study, the probability of survival in the urban area was 88.7% [CI95% = 87.8-89.6%] and in the rural area it was 83.9% [CI95% = 81.1% - 86.3 %]. For the last year the gap tends to increase; in the urban area the probability of survival was 43.4% [CI95% = 37.8% - 48.8%], while in the rural area it was 19.83% [CI95% = 9.9% - 32.2%]. The Logan-Rank test shows a higher diabetic death risk in patients living in rural areas (Chi2 = 27.23, p-value = 0.00 and NS = 5%). The Cox regression indicate that a diabetic patient from the rural area, presents a death risk of 26.3% [CI95% = 17.2% - 34.5%] greater than the urban patients. In both areas, death probability increases with age (1048) [CI95% = 1.04-1.05]. **CONCLUSIONS:** The survival probability remained high during the first two years and then decreases at a higher rate in the rural area. There is a significant gap in services access and / or medicines for the control of DM at the urban-rural level. A medium-term policy would be the implementation of DM risk management programs and the timely supply of medicines to patients in rural areas.

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CHARACTERIZATION OF PATIENT ACTIVATION, CLINICAL ASSESSMENTS, AND PATIENT REPORTED OUTCOMES IN T2DM PATIENTS

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OBJECTIVES: Characterize baseline clinical and patient-centric characteristics of type 2 diabetes mellitus (T2DM) patients who met criteria for an online patient engagement tool. **METHODS:** This study analyzed pooled baseline data from T2DM patients identified for a prospective evaluation of an online patient engagement tool at two sites; Henry Ford Health System and Northwell Health. Patients were eligible if they were ≥18 years of age, diagnosed with T2DM, and had a baseline Patient Activation Measure (PAM) level 2 'Becoming Aware' or 3 'Taking Action'. Clinical assessments and patient reported outcomes (PROs) were collected online and described using summary statistics. **RESULTS:** 662 participants consented and provided PAM data, with 15.9% and 48.8% at PAM levels 2 and 3, respectively. Patients at levels 1 (5.4%) and 4 (29.9%) were ineligible. 363 patients met all eligibility criteria for this analysis. Participants were primarily white (58.4%), females (59.0%) with a mean age of 57.4 (SD: 11.1) years and PAM level of 3 (76.6%). Mean time since diagnosis of T2DM was 10.4 (SD: 8.3) years. The most common comorbidities were hypertension and hypercholesterolemia/hyperlipidemia (20.7% each). 39.4% of patients had hemoglobin A1c ≥8.0% (mean: 8.0%, SD: 1.8) and mean body mass index (BMI) was 36.3 (SD: 7.4) kg/m², with 80.2% being considered obese (BMI ≥30 kg/m²). Mean physical and mental component summary scores from the Short Form 12 were 40.9 (SD: 16.1) and 44.9 (SD: 17.1), respectively, indicating impaired functioning in each dimension. Mean Diabetes Distress Scale scores indicated moderate regimen-related distress (3.1, SD: 1.2) and emotional burden (2.7, SD: 1.2), suggesting clinical attention is necessary. **CONCLUSIONS:** Clinical measurements and PROs in our population of T2DM patients with PAM level 2/3 suggest a need for clinical and lifestyle intervention. Further research is needed to confirm appropriate clinical intervention and the potential effectiveness of targeted patient engagement tools.

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COMPLICATIONS RELATED HEALTH UTILITY DECREMENTS FOR TYPE 2 DIABETES POPULATION IN THE UNITED STATES

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OBJECTIVES: The study aimed to develop a complete equation to examine health utility decrements associated with current and history of the complications among type 2 diabetes patients. **METHODS:** Health Utilities Index Mark 3 (HUI3) (range: 0-1) was used to measure the quality of life in the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial. Five macrovascular complications (myocardial infarction (MI), congestive heart failure (CHF), stroke, angina, and revascularization surgery (RS)) and twelve microvascular complications (nephropathy (4 levels), retinopathy (4 levels) and neuropathy (4 levels)) were included in this study. Both ordinary least squares (OLS) model and fixed effect model were applied to estimate the complication-related decrements on health utility scores, adjusting for demographic characteristics. **RESULTS:** Age at diagnosis (-0.002 per year), female sex (-0.043), education below college (-0.051), current smoker (-0.054), high BMI (-0.007 per unit) and longer diabetes duration (-0.005 per year) were associated with lower quality of life, and compared to blacks, Hispanics (-0.044) or whites (-0.019) were also associated with lower quality of life (all p<0.05). All macrovascular complications had statistically significant impact (i.e., p<0.05) on health utility scores: MI (event year: -0.043, successive years: -0.011), CHF (event year: -0.092, successive years: -0.041), stroke (event year: -0.203, successive years: -0.102), angina (event year: -0.011, successive years: -0.032), revascularization (event year: -0.038, successive years: -0.016). For those 12 included microvascular complications, only renal failure (-0.026), severe vision loss (-0.058), and severe pressure sensation loss (-0.067) were found to be significantly associated with lower health utility. **CONCLUSIONS:** Macrovascular and microvascular complications were associated with patients' quality of life. A complete health utility equation from the ACCORD study could help researchers to improve cost-effectiveness study.

PDB69

VALUING HEALTH-RELATED QUALITY OF LIFE FOR INPATIENTS WITH DIABETES-RELATED COMPLICATIONS IN CHINA

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OBJECTIVES: Disease burden of type 2 diabetes (T2DM) is escalating. Quite a few studies have evaluated the health-related quality of life (HRQOL) of overall T2DM patients, but few focused on that of inpatients with specific diabetes-related complications. Reliable estimates of the impact of complications on HRQOL are important to understand the event burden and serve for economic evaluation. This study aims to estimate the utility-based HRQOL of inpatients with diabetes-related complications in China, and explore the influencing factors. **METHODS:** This is a cross-sectional study conducted in a tertiary hospital in Shandong, China. T2DM patients (≥18 years) hospitalized during January, April and May 2017 for their complications, including ischemic heart disease (IHD), myocardial infarction (MI), congestive heart failure (CHF), stroke, impaired vision (IV), end-stage renal disease (ESRD), ulcer or amputation were recruited. The EuroQOL 5-dimensions 3-level (EQ-5D-3L) instrument was administered to these inpatients through face-to-face interviews. Clinical and sociodemographic data were collected from the survey. One-way analysis of variance and multiple linear regression analysis were performed. **RESULTS:** 802 T2DM inpatients (female 43%) provided data. Mean age was 62.67(SE:0.4) years. The most prevalent problems reported were impairments in Usual Activities. Mean EQ-5D index score of the total sample was 0.562(SE:0.007), with EQ-VAS score of 61.72(SE:0.606). HRQOL varied between complications with significant differences. Mean EQ-5D index scores were: IHD 0.620(0.012), MI 0.434(0.020), CHF 0.471(0.019), stroke 0.472(0.018), IV 0.714(0.012), ESRD 0.693(0.012), ulcer 0.431(0.029), and amputation 0.395(0.027). Mean EQ-VAS scores were: IHD 65.26(1.120), MI 58.84(1.722), CHF 56.70(1.800), stroke 58.59(1.565), IV 66.18(1.418), ESRD 63.57(1.568), ulcer 60.86(2.589),