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Studies that examined satisfaction with care in older adults are scarce. The aim of this research was to analyse satisfaction among older adults considering mental health, socio-clinical and health system factors and by age category. Data come from the Étude sur la Santé des Aînés Services study including 1,624 adults aged  $\geq 65$  years recruited between 2011-2013 in primary care in Quebec. Patient satisfaction was assessed during interviews with questions adapted from the Primary Care Assessment Survey. Mental health (anxiety, depression, suicidal ideation, psychological distress, cognition), social support, quality of life, the presence of pain and chronic conditions were self-reported. Health service use was extracted from administrative registries. Logistic regressions stratified by age were used to examine the associations of low satisfaction in three dimensions of care. For continuity of care, the determinants of low satisfaction were pain and attraction index for psychiatric services in adults 65 to 75 years versus anxiety, cognition and hospitalizations in adults 75 years and older. For patient-provider interactions, the determinants were psychological distress, attraction index for psychiatric services in adults 65 to 75 years versus quality of life and cognition in adults 75 years and older. For adequacy of care, anxiety, psychological distress, social support, pain, quality of life and attraction index for psychiatric services were significant in adults 65 to 75 years versus quality of life and cognition in adults 75 years and older. Results highlight different patterns of satisfaction by age category that should be used to improve care delivered in primary care.

#### DEVELOPMENT OF A CLAIMS-BASED ALGORITHM TO IDENTIFY PATIENTS WITH AGITATION IN ALZHEIMER'S DEMENTIA

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Agitation is common in patients with Alzheimer's dementia. Lack of a consensus definition has limited our understanding of the prevalence, patient profile, and added healthcare burden of agitation in Alzheimer's dementia (AAD). We developed an algorithm to identify AAD patients using 100% of Medicare Fee-For-Service administrative claims from 2011-2017. We adapted the International Psychogeriatric Association (IPA) 2015 definition, which had not been tested using real-world data. Patients were required to have 2+ claims  $\geq 30$  days apart for Alzheimer's disease and dementia, and continuous enrollment with medical/pharmacy coverage for 6-months pre- and 12-months post-index diagnosis. The AAD cohort included patients with 2+ claims  $\geq 14$  days apart with ICD-9-CM/ICD-10-CM codes selected based on the IPA definition (e.g., dementia with behavioral disturbance, irritability/anger, restlessness/agitation, violent behavior, impulsiveness, wandering). Patients with severe psychiatric disorders were excluded. The final population included 255,669 patients with (34.6%) and 482,710 patients without agitation (65.4%). The mean age in both populations was 82 years. Although the majority of patients in both

groups was female, the proportion of males was slightly larger in the AAD group (31.2% vs 29.7%). Patients in the AAD group were also more likely to be low-income (dual-eligible: 44.0% vs 39.6%), disabled (10.4% vs 9.3%), and using antipsychotic and antidepressant medications. The 2 populations had similar comorbidity rates. AAD prevalence may be underestimated using claims data, given imprecise and under-coding. These findings suggest AAD patients can be identified using a claims-based algorithm to support early interventions that can potentially improve outcomes and reduce costs of care.

#### EXCLUSION OF MEDICARE ADVANTAGE ENROLLEES FROM MEDICARE HEALTH OUTCOMES ANALYSES: POTENTIAL FOR BIAS

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The aim of this paper is to assess the extent of the potential bias introduced by the exclusion of the Medicare Advantage (MA) population— an increasingly sizeable (31% of all beneficiaries in 2017) subset of the Medicare population which does not provide claims data to the Centers for Medicare and Medicaid Services— from Medicare-based health outcomes and epidemiologic analyses. Using self-reported data from the Health and Retirement Study together with monthly information on Medicare enrollment, we compared MA enrollees with individuals enrolled in traditional Medicare (TM) on 42 variables representing demographic, socioeconomic, adverse health behavior and health status-related characteristics over the 1991-2015 period. We used both univariate analysis (t-tests and standardized differences) and multivariate logistic regression to compare the two groups. We found that apart from differences in economic (higher in TM group) and education status (lower in MA group) – which have been increasing in magnitude over the 1991-2015 period— the MA subset was highly comparable with the traditional Medicare (TM) population. Even though the TM population was characterized by slightly higher levels of morbidity, the resulting crude prevalence rates for common age-related diseases in the TM/MA groups were within each other's 95% confidence intervals and did not represent a major source of bias. MA membership was not associated with increased mortality at any point over the 1991-2015 period. We conclude that exclusion of the MA population will not lead to notable bias in health outcome analyses apart from those for which income and education are important explanatory factors.

#### FUNCTIONAL CORRELATES OF SELF-REPORTED ENERGY IN THE HEALTH, AGING, AND BODY COMPOSITION STUDY

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While fatigue in older age is well studied, the clinical relevance of maintaining higher energy late in life is less understood. We explored associations of self-reported energy with cognitive performance, depressive symptoms, and physical