Title
Sociodemographic differences in the use of evidence-based therapies for medicare beneficiaries with diabetes in managed care.

Permalink
https://escholarship.org/uc/item/1498w14q

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Publication Date
2000-04-01

Peer reviewed
these 20 (60%) patients were still eligible for at least one trial. There was a modest positive correlation (r = 0.27) between eligibility for any RCT and treatment with warfarin and a modest negative correlation (r = -0.30) with age and warfarin use. There was no association between warfarin use and Charlson comorbidity score (r = -0.04).

CONCLUSION: These preliminary data found that the majority of patients in a teaching clinic would have been eligible, based on published criteria, for at least one RCT studying the efficacy of warfarin to prevent stroke in patients with atrial fibrillation, and that advancing age, but not comorbidity, was associated with less warfarin use.

DOES HAVING SOMEONE TO TALK TO MAKE A DIFFERENCE?: SOCIAL SUPPORT AS A PREDICTOR OF HOSPITAL LENGTH OF STAY. C. South Foster, ME Charlton, Division of General Internal Medicine, New York Presbyterian Hospital, New York, NY

PURPOSE: Despite convincing evidence linking poor social support with poor health outcomes, questions about social support are not routinely asked as part of the medical interview. The purpose of this study was to determine the prevalence of poor social support among hospitalized patients and to determine the impact of poor social support on length of stay and cost of hospitalization.

METHODS: During a six week period, patients admitted to the internal medicine service were asked to complete a questionnaire designed to assess the psychosocial needs of hospitalized patients. Social support was determined by asking patients whether or not they had someone who they could talk to about important things in their life. Their responses were also asked about their self-perceived health status. The burden of comorbid illness was determined by the Charlson comorbidity index. Diagnosis related groups (DRG) were abstracted from patient charts. Variation in the length of stay was determined by calculating the difference between the estimated length of stay for that DRG and the patients’ actual length of stay. Total cost of hospitalization was obtained from the hospital’s computerized data base.

RESULTS: Of the 317 patients interviewed, 12% reported that they did not have a source of social support. Their mean age was 64% were female, and 38% were African-American or Latino-American. Patients who did not have a source of support were more likely to describe their health as poor (P = 0.01). The most common reasons for admission among patients with poor social support were for cardiovascular, pulmonary, and HIV related illnesses. The mean length of stay for patients who were admitted for these conditions and who lacked a source of support was 13 days as compared to 7.5 days for those patients who had a source of support (P = 0.001). Patients with poor social support stayed in the hospital an average of 5 days longer then expected for their DRG. The total hospital cost for these patients was on average $3,000 higher.

On multivariate analysis, after adjusting for age, race, sex, functional status and Charlson comorbidity score, poor social support remained as a significant predictor of length of stay for patients admitted with cardiovascular, pulmonary, and HIV related illnesses. (P = 0.02)

CONCLUSION: Having someone to talk to is an important factor which physicians may often over look. Approximately one out of ten patients admitted did not have a source of social support. These patients were more likely to describe their health as poor and stayed in the hospital longer than expected. Innovative methods of identifying patients with poor social support and interventions which enhance social support may improve patient outcomes as well as decrease health care cost.

ESTIMATING HIP FRACTURE MORBIDITY, MORTALITY, AND COSTS. SS Bhathalwhite, NF Col, UK Hetc, JB Wong, Division of Clinical Decision Making, Informatics, and Telemedicine, Tufts-New England Medical Center, Boston, MA

PURPOSE: Hip fractures lead to approximately 300,000 hospitalizations and 50,000 deaths annually in the US, but published estimates of the long-term consequences of hip fractures are non-ALD recipients. Less than 6 months of abstinence from alcohol pre-transplantation was associated with poor and stayed in the hospital longer than expected. Innovative methods of identifying patients with poor social support and interventions which enhance social support may improve patient outcomes as well as decrease health care cost.

RESULTS: Among 10 studies examining outcomes between 6 and 12 months after hip fracture, our meta-analysis suggested that 14 ± 5% of patients (n = 3067) required long-term nursing home care. In 4 studies, 34 ± 11% (n = 1259) experienced permanent disability. Overall, hip fracture decreased life expectancy by 23 ± 7 years with an increased mortality of this mortality (18%) occurring within the first 6 months. Sixteen percent of that life expectancy is spent in a nursing home (6.9 years, on average). Our model estimated a lifetime attributable cost to hip fracture of $737,200 with $65,300 occurring during the first six months. The most important factors influencing costs (in order of importance) were the 1) long term nursing home rate, 2) daily nursing home cost, 3) hospitalization costs and 4) inclusion of economic value for home care delivered by unpaid caregivers.

CONCLUSION: Hip fractures result in significant mortality, morbidity, and costs. Most of the attributable expenses result from functional losses in the activities of daily living, leading to long-term nursing home or supplemental home care. Based on this analysis, the estimated lifetime cost for the 311,000 hospitalized hip fractures in the US in 1997 may exceed $19 billion. These results emphasize the importance of screening and treatment interventions to decrease the incidence of hip fracture, especially as the US population ages.

QUALITY OF LIFE, WORK AND ALCOHOL USE AFTER LIVER TRANSPLANTATION. DM Borrow, I. Okin, AE Baron, EB Keeffe, DK Owens, Medicine, VA Health Care System, Palo Alto, CA; Medicine, Stanford University School of Medicine, Stanford, CA; Statistics, Stanford University, Stanford, CA

PURPOSE: Approximately 7500 liver transplants are performed around the world at an average 1-year cost of $280,200 per transplant. Alcoholic liver disease (ALD) is the second leading cause of liver failure necessitating transplantation. An understanding of recipients’ quality of life (QOL), employment and alcohol-use outcomes is essential for counselling pre- and post-transplantation patients. Our purpose was to evaluate parameters of QOL, employment, and alcohol use among liver transplant recipients with ALD and other etiologies of liver failure (non-ALD).

METHODS: We identified 5473 potentially relevant articles using structured MEDLINE and Embase searches and 32 additional references from articles’ bibliographies. We included studies if they reported an assessment of quality of life (QOL), employment or alcohol consumption; reported either pre- and post-transplantation data or had a comparison group; and were written in English. We combined studies to calculate summary proportions, odds ratios, and performed a sign-test to evaluate the direction (positive or negative) of the effect of transplantation on QOL.

RESULTS: Among 89 articles, 84 of the 9055 transplant recipients met our inclusion criteria. We found significant post-transplantation QOL improvements (p < 0.05) in Karnofsky, Sickness Impact Profile, and Nottingham Health Profile scores; physical health, sexual functioning, daily activities, general QOL, and social functioning; but not psychological health. Employment among ALD vs. non-ALD recipients was 29% vs. 59% pre-transplantation and 33% vs. 85% at three years post-transplantation (p < 0.0001). Non-ALD recipients using alcohol had lower rates of employment than those who abstained; however there was no such association for ALD recipients. Although, there was no difference in the proportion of ALD and non-ALD recipients reporting alcohol use post-transplantation (4% vs. 5% at 6 months, 17% vs 16% at 12 months), the non-ALD recipients were more likely to drink moderately (p < 0.0001), whereas ALD recipients were more likely to drink excessively (p < 0.05). The odds ratio for alcohol use among those patients with less than 6 months of pre-transplantation abstinence was 7.8 (95% confidence interval: 4.0-15.3).

CONCLUSION: Liver transplantation provides clinically important increases in functional status in both ALD and non-ALD recipients. Prior to transplantation and at long-term followup, substantially fewer ALD recipients are employed than non-ALD recipients. Less than 6 months of abstinence from alcohol pre-transplantation is a strong predictor of post-transplantation alcohol use.

SOCIODEMOGRAPHIC DIFFERENCES IN THE USE OF EVIDENCE-BASED THERAPIES FOR MEDICARE BENEFICIARIES WITH DIABETES IN MANAGED-CARE. AF Brown, PR Guifilner, SR Starr, MF Shapiro, CM Mangione, Department of Medicine, UCLA, Los Angeles, CA; MCP Hahnemann University, Philadelphia, PA; RAND, Santa Monica, CA

PURPOSE: To determine whether the use of evidence-based therapies for primary and secondary prevention of cardiovascular disease and nephropathy in older persons with diabetes enrolled in Medicare managed care (MCC) is influenced by sociodemographic characteristics.

METHODS: Telephone interviews and clinical examinations were performed on a random sample of subjects with diabetes cared for in a Medicare managed care plan that contracts with 17 provider groups in Los Angeles. Current medications were inventoried at the study’s clinical examination. Patients were questioned about sociodemographic characteristics and health status. The evidence-based therapies evaluated included primary and secondary prevention with cholesterol lowering medications overall and HMGCoA reductase inhibitors specifically: aspirin use in all patients and for those with a history of coronary heart disease (CHD); beta-blocker use in persons with a history of myocardial infarction (MI); and angiotensin converting inhibitor (ACEI) use. The influence of age, gender, race/ethnicity, income, Medicare status and use of published guidelines on use of each therapy was tested with a series of logistic regression models, adjusting for health status using the SF-12 and for comorbid illness.

RESULTS: Clinical examinations were completed in 308 of 466 eligible persons (66%). Mean age 75 ± 5 years; 47% women; 51% white, 22% Latino, 17% African American, and 6% Asian Pacific Islander; 55% earned under $20,000 per year; 8% received Medicaid; and 28% had not graduated from high school.

Use of Evidence-Based Therapies—Odds Ratio (p).

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<tr>
<th>Therapeutic Plan</th>
<th>Use of Evidence-Based Therapies—Odds Ratio (p).</th>
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<tr>
<td>Age &gt;75 Female Medicaid</td>
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HS Grad: More than $20,000; HS Grad: Less than $20,000; Age: 75 years or older; Medicaid: Medicaid; Income: Income.
had the same pharmacy benefit, there were several sociodemographic differences.

CONCLUSION: In this cohort of Medicare MC patients with diabetes, all of whom agreed the brochure was valuable and easy to understand and 74% believed it contained information and encouraged discussion with one’s doctor.

METHODS: The target population was AA, predominately Medicaid-eligible men enrolled in two health care organizations. The 12-page brochure was tailored to the needs and preferences of these men based upon results from a telephone interview and a series of focus groups. To then evaluate the brochure we telephoned 200 eligible practice visitors 40 to 75 years of age, of whom 104 completed a baseline pre-brochure interview. There were then mailed these men, 58 of whom also com-
peted a post-brochure interview. Those completing versus not completing the sec-
ond interview did not differ in measured factors.

RESULTS: Half are over the age of 60 and have fewer than 12 years of formal edu-
cation. Knowledge of prostate testing was limited. At baseline 37% identified ei-
ther rectal exam or PSA test as included in testing and 73% were uncertain about the possibility of a false positive test result. Attitudes toward testing were highly favorable. Over 85% believed that “testing saves lives” and that “all men should be tested”. At baseline, 35% had made a testing decision; 30% to be tested and 5% to talk to their doctor. Factors independently associated with having made a decision included age <60, recognizing possibility of false test results, and belief that one’s doctor recommends testing (a factor closely related with favorable test attitudes). Among the 58 men completing pre and post interviews, 97% agreed the brochure was valuable and easy to understand and 74% believed it provided the right amount of information about pros and cons. The knowledge score increased from 2.5 to 3.2 on a 5-point scale (p = 0.001) but there was no change in the favorable pre-brochure testing attitudes. Testing decisions did not change. The proportion of men choosing to be tested increased by 20%. No man decided to not be tested.

Decision %Pre %Post
Be tested 33 53
Talk to doctor 3 9
No decision 64 38

CONCLUSION: We conclude that a carefully developed and targeted “non-advo-
cacy” brochure may increase knowledge but does not consistently reduce (and may increase) enthusiasm for testing among men with pre-existing and strong be-
iefs about its value.

DOMESTIC VIOLENCE DETECTION: LESSONS LEARNED FROM PREGNANT AND NONPREGNANT VICTIMS. SA Buranosky, KA Dowd, BH Hanusa, SH Scholle, Division of General Medicine and the Center for Research on Healthcare, University of Pittsburgh, Pittsburgh, PA

OBJECTIVE: Routine screening and counseling for domestic violence (DV), de-
fining as physical, emotional, and sexual intimate partner abuse, is recommended in primary care. The purpose of this study was to assess the effects of this screen-
ning on pregnant and nonpregnant victims.

METHODS: Women who were counseled for DV in a university obstetrics/gyneco-
ologic clinic from 6/98 to 3/99 were identified from forms completed after a woman had been counseled (N = 69). Of the 69 victims identified, medical charts were available for 50 (72.5%). Data on demographics, abuse, health care use, physical and mental health problems, and social work referral patterns were abstracted from medical and billing records.

RESULTS: Of the 50 women in the study, 26 (52%) were pregnant. Detection of DV occurred more frequently at return vs new patient visits (54% vs 20%). Couns-
seling rarely occurred for emotional abuse alone (10%), yet was present in 76% of the cases. The predominant reason for receiving counseling was physical abuse (84%). Of the women with data available on the last incidence of abuse (N = 34), 27 (79%) had been abused in the past month; yet, 63% were not living with their abuser. In addition, only pregnant victims (6/14) reported new-onset abuse. Pregnant women were more likely to be referred to social work for reasons other than DV (47.6% vs. 21.4%, PE = 0.16), such as substance abuse and de-
pression, with DV subsequently being detected by the social worker. Of the total number of victims referred to social work for DV (N = 27), 48.1% did not see a social worker the day of detection. Depression (54%), tobacco use (46%), illegal drug use (16%), and history of STD's (64%) were equally prevalent in both pregnant and non-pregnant patients.

CONCLUSION: Return clinic appointments with questioning at each visit may in-
crease the detection of DV, especially new-onset abuse. Since most victims were abused by partners with whom they did not live, most assume that a woman who does not reside with her partner is safe. The time between DV detec-
tion and the social work visit places a woman and sometimes a fetus at risk for further abuse. Social work referral for psychosocial reasons, such as depression and substance abuse, may yield increased rates of detection of domestic violence.

DETERMINANTS OF ALCOHOL ADVICE OR TREATMENT AMONG AT-RISK DRINKERS IN THE OUTPATIENT SETTING. RESULTS FROM THE ACQUIP STUDY. MI Burman, MB McCabe, SD Finn, KA Bradley, CD Miller, Center of Excellence, VA Puget Sound Health Care System; Department of Medicine, University of Washington, Seattle, WA

PURPOSE: Little is known about factors that lead primary care providers to coun-
sel patients about their drinking. We examine rates of alcohol-related advice and treatment reported by male at-risk drinkers who receive primary care in the VA, and identify factors associated with at risk drinkers’ reports of not receiving any alcohol-related advice or treatment in the past year.

METHODS: We surveyed patients followed at seven VA General Internal Medicine Clinics participating in the VA Ambulatory Care Quality Improvement Project (AC-
QUIP). At risk drinkers, identified using a validated augmented CAGE questionnaire, were sent the ACQUIP Drinking Practices Questionnaire (DPQ) which includes the Alcohol Use Disorders Identification Test (AUDIT) and three questions about alco-
hol-related advice or treatment. Other data collected included demographic char-
acteristics, patient reports of health problems, questions about health-related quality of life (SF-36), and patient satisfaction. Site investiga-
tors indicated whether a standard alcohol-screening program had been instituted.

RESULTS: The DPQ was returned by 3,891 at-risk drinkers (57% response). Re-
sponses were primarily male (76%), Caucasian (78%) and 47% (1,812) were 60. At least one symptom of dependence in the preceding year was reported by 819 (21%) respondents. Among DPQ respondents, 700 (18%) indicated that in the past year they had been advised by their primary care provider to drink less, 661 (17%) had been advised to quit, and 156 (4%) had received alcohol treatment. Ex-
cluding those treated in the past year, a total of 784 (21%) received advice to change their drinking. Advice was more common among patients who were younger, reported less education, were unmarried, had lower income, reported liver disease, or smoked. Multivariate logistic regression revealed that the follow-
ing groups of at-risk drinkers were significantly more likely to report not receiving any alcohol-related advice in the past year: patients who drank < 14 drinks/week (OR 1.99), those without symptoms of alcohol dependence (OR 3.33), who did not receive a drinking problem diagnosis in the past 12 months (OR 3.22), who did not receive a diagnosis in the past 12 months (OR 1.62). Interpretation of clinical-based screening with the CAGE questionnaire was not significantly associated with receipt of advice to modify drinking behavior (OR 1.12).

CONCLUSION: While primary care providers appear to be focusing their alcohol counseling on those at-risk drinkers with the most severe problems, the number of patients receiving alcohol counseling continues to be a small proportion (21%) of those who might benefit from it.

INCREASING PREVALENCE OF TRIMETHOPRIM-SULFAMETHOXAZOLE RESISTANT ESCHERICHIA COLI. W Burman, P Breese, H Botz, T Mackenzie, PS Mehler, Denver Health Medical Center, Denver, CO

PURPOSE: Acute uncomplicated cystitis is one of the most common community-acquired infections in women during antiseptic treatment with trimethoprim-sulfamethox-
azole for uncomplicated cystitis has been a widely utilized strategy. However, there has been increasing resistance to this antibiotic in Escherichia coli, the most common cause of these infections. The purpose of our study was to deter-
mine the trends in this resistance among E. coli uropathogens and to ascertain if there are risk factors, which predict this resistance in acute cystitis.

METHODS: There were two parts to the study: Part A was a retrospective study of antibiotic resistance in 786 urine cultures from the microbiology computer system of all patients with E. coli (≥10^5/ml). Part B was a prospective observational study performed at multiple different clinic sites at Denver Health. All patients with symptoms typical of uncomplicated cystitis seen between July 1998 through Sep-
tember 1998 had a questionnaire completed. Treatment details were at the discre-
tion of the care provider. All patients with an isolate resistant to trimethoprim-
sulfamethoxazole were phoned and asked to return to clinic where a repeat urine culture was obtained and a second questionnaire was completed.

RESULTS: The rate of resistance increased from 2% in 1981 to 26% in 1998. Fact-
ors associated with a resistant urinary isolate in these urine cultures were: resistance in the past six months (OR = 2.5 [1.0-6.1]), and travel outside the United States in the past six months (OR = 6.0 [1.3-28.6]). Hispanic ethnicity, compared to persons of other racial/ethnic backgrounds and age less than 3 years (P < 0.01) also predicted a greater rate of resistance in the retrospective study. Race in patients without risk factors. This will likely require closer attention to local anti-
biotic susceptibility data and a change in empiric treatment strategies.