Use of vision services and satisfaction with care among medicare beneficiaries with fee-for-service versus managed Medicare.

Permalink
https://escholarship.org/uc/item/1jz7j2nc

Authors
Mangione, CM
Keeler, EB
Adams, JL
et al.

Publication Date
2000-04-01

Peer reviewed
With full risk contracting, physician groups are motivated to monitor the appropriateness and volume of referral care. The most frequent management strategies used in all regions at similar proportions include: mandatory pre-authorization from the group for specialist visits (43%) or procedures (76%); pre-authorization by the PCP for specialist visits (72%); PCP-level profiling with feedback (74%); and implementation of formal guidelines that provide criteria with regard to appropriateness of use of referral care (74%).

CONCLUSION: Financial and organizational structure varies widely for the groups which provide the majority of care to the managed care populations in these regions. Linkage of these structural characteristics to patient level data will be critical to determine whether physician group characteristics are associated with better outcomes of care.

WHICH PRIMARY CARE PATIENTS WITH ALCOHOL DISORDERS RECEIVE TREATMENT? C Mansel, A Spilo II, A Lee, I Katz. General Internal Medicine, University of Alabama at Birmingham, Birmingham, AL; CHC/ER, Bedford VAMC, Bedford, MA

PURPOSE: Little is known about possible differences between primary care patients who have and have not been treated for alcohol disorders. We examined the health status and clinical characteristics of ambulatory patients with alcohol disorders (AD) who had and had not received treatment.

METHODS: Cross-sectional sample and survey of 6829 males who use VA ambulatory services in the greater Boston area. Patients were defined as having AD if CAGE was greater than or equal to 2 and current (CAD) if they had had a drink in past month, or else abstinent (NAD). According to self-report patients were further classified as treated (CADT or AADT) or never treated (CADNT or AADNT); patients with a CAGE ≥ 0 and no history of treatment were classified as NOAD. The total number of physical (PHYS) and psychiatric (PSYCH) comorbidity items was based on a medical history interview. Health status was measured with the SF-36 from the Medical Outcomes Study using two summary scores, PCS (physical component summary scale) and MCS (mental component summary scale). Higher scores denote better function. Patients with current AD completed the alcohol section of the QODS; a diagnostic interview for DSM-III-R. ANCOVA adjusted for age was used to compare PHYS, PSYCH, PCS, and MCS scores. Tukey’s test was used for multiple between group comparisons; all p values are <0.05 two-tailed. Results: 2425 of 4236 (57%) eligible patients completed the survey.

CAUSES OF ANTIBIOTIC RESISTANCE: ATTITUDES AND PERCEPTIONS OF RESIDENTS COMPARED TO ATTENDINGS. E Martinez, WC Wester, L Durairaj, DN Schwartz, S Husain, AT Evans, Department of Medicine, Cook County Hospital, Chicago, IL

PURPOSE: Antibiotic resistance is a growing health problem. Little is known about the attitudes and perceptions of physicians regarding its causes, and no study has ever been published comparing internal medicine residents to attendings. It is perceived that residents don’t have an adequate appreciation of antibiotic usage and its ramifications.

METHODS: A survey containing a 19 item self-administered questionnaire was sent to 448 internal medicine physicians in 4 Chicago hospitals; 424 (87%) were returned completed. The survey asked physicians to rank potential causes of antibiotic resistance, ranging from “unimportant” to “extremely important.” The sample included 243 internal medicine residents and 181 internal medical attendings. The residents included 143 from a public hospital and 100 from a university hospital, and the attendings included 114 general internists, 21 ID specialists, and 46 other specialists.

RESULTS: Resident physicians consistently ranked all the potential causes of antibiotic resistance as high or higher (in terms of potential importance in causing the problem) than attending physicians. Specifically, residents ranked 6 potential causes at a statistically significantly higher level compared to attendings. These included: 1. Prescribing antibiotics for self-limited non-bacterial infections. 2. Prescribing antibiotics for shorter than recommended duration. 4. Prescribing antibiotics empirically without a definite diagnosis of bacterial infection. 5. Prescribing broad spectrum antibiotics when equally effective narrower spectrum antibiotics are available. 6. Having access to good information on local antibiotic resistance patterns. There were 12 potential causes ranked at similar levels by residents and attendings. Only one cause was ranked at a statistically significant lower level by resin-