Title
Seniors and prescription drug costs - Opportunities to save? A lesson from Medicare plus Choice.

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There were no differences in any of the 5 subscales on the MCQ or the MAQ’s Overall, Symptom, or Activity subscales. Patients in the PH intervention group had improved MAQ Emotion (p = .04) and Environment scores (p = .03). There were also no differences in patients’ satisfaction with their physicians or pharmacists, medication compliance, emergency room visits, hospitalization (≥1 hospitalization in the past year), or the costs associated with medication (>$6,261/patient). Physicians viewed guidelines as helpful reviews but reinforced “cookbook medicine” to lower health care costs.

CONCLUSION: Computer delivery of RAD care suggestions to primary care physicians and/or outpatient pharmacies did not improve patients’ subjective or objective outcomes. Effective interventions will require enhancing the message (e.g., with symptom information) or its delivery (e.g., requiring responses) or providers’ attitudes toward computers and guidelines suggesting how they should provide care.

WHAT IS THE CONCORDANCE BETWEEN PATIENT SELF-REPORT AND MEDICAL RECORD AS A DATA SOURCE FOR MEDICATION USE? D. Tsianos, W.P. Chen, H.H. Liu, J. Adams2, C. Damberg, D. Carlisle1, C.M. Mangione3, K.L. Kahn1; 1UCAL Dept of Medicine, Los Angeles, CA; 2RAND, Santa Monica, CA; 3PGH, San Francisco, CA (Tracking ID #52160)

BACKGROUND: Medical record data may be considered the preferred data source for treatments recorded by patients (pts), but review is costly and often incomplete. In lieu of medical record data, pt self-report is often used, but questions arise about the completeness and validity of these data for evaluating the quality of care.

METHODS: As part of the UCLA/PGH Physician Value Check Validation Study, we examined medication use and data collected using a survey and medical record abstraction for pts with diabetes, ischemic heart disease, asthma or COPD, or chronic low back pain, from 3 West Coast states. We surveyed 1656 patient from 48 participating medical organizations (response rate 63%). The mailed, self-administered survey queried pts about utilization of health status, process of care over the previous time window, as well as medication use. MRs for pts with survey data were reviewed and abstracted by trained nurses to collect data from the same time window. We evaluated concordance between the 2 sources for the following prescription med categories: lipid-lowering meds including statins, antidepressants, ACE inhibitors for 1270 pts, sulfonylurides for 404 pts with diabetes, beta blockers for 338 pts with heart disease, and inhaled corticosteroids for 338 pts with asthma or COPD, using the McNemar’s Chi square test, kappa statistic, and the Sensitivity and Specificity of the self-report (using the MR as the gold standard). We compared levels of concordance by age (≥65 vs <65), race/ethnicity (non-Hispanic white vs other), education (≥12 years vs <12 years) and annual income ($30,000 vs $30,000).

RESULTS: Using data from pts with both survey and MR review, we analyzed a subset of data for pts with at least one visit to a clinician during the two-year study window (n = 1270). The pts of MR was used as a measure to both data sources ranged from 11% for antihypertensives among all pts to 44% for sulfonylurides among diabetic pts. Kappa statistics ranged from 0.57 for anti-diuretics to 0.76 for beta-blockers indicating fair to good agreement between data sources beyond what would be expected by chance alone. Sensitivity ranged from 51% for anti-diuretics to 78% for beta-blockers. Specificity ranged from 88% for sulfonylurides use to 98% for anti-depressant use. Concordance between data sources varied by patient age, race/ethnicity, education and income, with lower levels of concordance associated with older age group, non-white race/ethnicity, and lower education and income levels.

CONCLUSION: Relying solely on a function of data source with concordance between data sources varying by patient characteristics. Quality of care scores may be affected. p < .05 for Test of Equal Kappa coefficients.

OUTPATIENT UTILIZATION AMONG CRONICLLY ILL PATIENTS IN MANAGED CARE. D. Tsianos, W.P. Chen, J. Adams2, H.H. Liu2, C. Damberg, D. Carlisle1, C.M. Mangione3, K.L. Kahn1; 1UCAL Dept of Medicine, Los Angeles, CA; 2RAND, Santa Monica, CA; 3PGH, San Francisco, CA (Tracking ID #52310)

BACKGROUND: Although inpatient utilization in managed care organizations has been studied extensively, less is known about outpatient utilization. We studied the number of visits and providers seen by a cohort of chronically ill patients to assess outpatient utilization using claims/encounter data (C/E) and data from medical records (MR).

METHODS: As part of the UCLA/PGH Validation Study, we obtained consent for review of C/E data from 48 (83%) of 58 medical organizations for 63% of 2287 chronically ill patients in 3 West Coast states. 38 medical organizations provided C/E data for these patients for a 24-month window. Medical records for patients with C/E data were reviewed and abstracted by trained nurses. C/E and MR data from 1516 patients from 34 (71%) of 48 consenting medical organizations. We excluded 11 patients with no claims or encounters during the 24-month study period, for a total of 1494 patients.

RESULTS: Using data from patients with claims, encounter, and medical record data for the same 24 month window, we analyzed a subset of data for patients with at least one visit to a clinician (i.e., physician or nurse practitioner) (n = 1148). Based on C/E and medical record data, the mean number of visits to a clinician during the study window was 23, including 11 visits to a primary care provider (PCP). Visit frequency varied by disease, from a mean of 19 for patients with low back pain to 26 for patients with diabetes. Patients saw a mean of 6 unique providers. We also examined the unique contribution of medical record data as compared with C/E data alone. Over 8% of visits and 3% of physicians would not have been measured using C/E alone. Medical record data provided additional information that was not captured by the C/E data for 300 patients (26%). With the addition of medical record data, 4% more patients were noted to have had ≥1 PCP visit, 4% more heart patients were noted to have had ≥1 cardiology visit, and 3% more diabetes patients were noted to have had ≥1 eye exam. CONCLUSION: Outpatient utilization among chronically ill patients in managed care organizations was high.

EFFECT OF LINKAGE OF MEDICAL CARE TO DRUG TREATMENT ON HOSPITALIZATION OF DRUG USERS WITH HIGH VERSUS LOW MEDICAL COMPLEXITY. B.J. Turner, C. Laine1, W.W. Hauck2; 1University of Pennsylvania, Philadelphia, PA; 2Aerolns of Improved Medical Care, Philadelphia, PA; 3Thomas Jefferson University, Philadelphia, PA (Tracking ID #52154)

BACKGROUND: Drug abuse is associated with substantial medical morbidity and demand for inpatient care. Improved delivery of medical care for drug users in drug treatment may improve health status and consequently reduce hospitalization. We examined the association of providing medical care onsite or in the same building as a drug treatment clinic on hospitalization of drug users with medical complexity in managed care organizations.

METHODS: We studied drug users enrolled in New York State Medicaid for >10 mos of both 1996 and 1997. We conducted surveys of directors of 125 methadone and/or medically-supervised drug free programs in 1998 regarding about linkage of medical care services in 1996–97. Responses reporting general and HIV medical care onsite or in the same building provide the best opportunity to reduce hospitalization of drug users.