Title
Unmet need for eye care treatment among older persons with diabetes in fee-for-service and managed Medicare.

Permalink
https://escholarship.org/uc/item/4jz45323

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Publication Date
2003-04-01

Peer reviewed
THE PREVALENCE OF DEMENTIA AMONG VULNERABLE OLDER ADULTS ATTENDING AN URBAN PRIMARY CARE CLINIC. M. Boustanian, C. M. Callahan, F.W. Unverzagt, M.G. Austrom, S.R. Counsel, H.C. Hendrie, Indiana University, Indianapolis, IN (Tracking ID #76833)

BACKGROUND: Primary care physicians provide the majority of care for patients with dementia. Although ethnic, economic, and educational backgrounds play very important roles in health care services, we are unaware of any epidemiological study that estimated the prevalence of dementia syndrome and its subtypes among vulnerable older adults in an urban primary care setting.

METHODS: Design: Cross-sectional screening program within primary care using the Community Screening Instrument for Dementia (CSI-D) followed by a confirmatory diagnostic stage for participants with positive screening. The CSI-D was specifically developed to minimize educational and racial bias in cognitive screening. Settings: Primary care health centers in Indianapolis. Participants: 2211 individuals aged 65 and older; 69% were women, 63% African-American, and 44% had eight years of education or less. Main Outcome measures: Dementia was diagnosed according to DSM-IV criteria by an expert panel including a geriatric psychiatrist, a neuropsychologist, a social psychologist, and a geriatrician using the results of formal neuropsychological testing and detailed information collected from patients, caregivers, and medical records.

RESULTS: Among 2,211 patients screened, 120 (5.4%) scored positive on the CSI-D and 170 (53% of the screened positive) agreed to formal diagnostic testing. The overall estimated prevalence of dementia was 6.6%. Among those who screened positive, 45.3% were found to have dementia, 26.1% had mild cognitive impairment (MCI), 23.6% were considered to have no cognitive deficit, and 5% had cognitive deficit due to mental retardation or long-standing psychiatric disorders. Among individuals diagnosed with dementia, 67% had possible or probable Alzheimer’s disease, 10% had vascular dementia and 10% had mixed vascular dementia and Alzheimer’s disease, and 15% had other types of dementia. The mean MMSE score was 17.6 (SD 5.2) for the dementia group, 22.6 (SD 3.2) for those with MCI, and 24.4 (SD 3.1) for those who screened positive but found to be normal.

CONCLUSION: Screening for cognitive impairment in primary care identifies patients with a diverse spectrum of cognitive deficits due to a range of neurodegenerative illnesses. A substantial proportion of patients refuse formal testing. These findings highlight the complexity of diagnosis and treatment decisions for dementia in primary care.

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PERCEIVED PALLIATIVE BENEFIT OF MEDICATIONS AMONG HOSPICE MEDICAL DIRECTORS: SURVEY IS NOT UNIVERSAL. S. T. Brown, J. J. Auten, C.T. Kassner, University of Colorado Health Sciences Center, Denver, CO (Tracking ID #74392)

BACKGROUND: There are no established guidelines regarding the palliative benefit of medications in the hospice setting. Which medications will be continued during hospice care is often dependent upon the individual physician. The objective of this study is to better understand the reasons why physicians choose to discontinue certain medications when a patient is admitted to a hospice.

METHODS: We conducted a self-administered survey by mail and email of medical directors of hospices participating in the Population-based Palliative Care Research Network (PbP/CNR). The respondents were asked background questions about their training, roles, and hospice experience. They were then given a list of 29 medications and asked to identify the most common reason they choose to discontinue each medication, if at all.

RESULTS: Of the 175 hospices surveyed, 54 medical directors have responded to date, representing 19 states and 45 hospices. The most common reason for stopping a medication, across all medications sampled, was that patients or family requested to discontinue it (30%). Consensus regarding benefit was present for only a small number of medications. Levodopa and oxcarbazepine were felt to have significant benefit, as more than 50% of respondents never stop them. In contrast, 79% of the respondents discontinue HMG CoA reductase inhibitors because there is no perceived palliative benefit. Cost predominated as the primary reason for discontinuing only erythropoietin and colony stimulating factors. Cost was noted to be a reason for discontinuing medication for only 8% of the responses. No consensus existed regarding the approach to the use of ACE inhibitors, digoxin, aspirin, anticoagulants, multivitamins, inhaled steroids, proton pump inhibitors, or amiodarone for atrial fibrillation in the hospice setting.

CONCLUSION: This study demonstrates that hospice medical directors clearly believe that some medications belong in the palliative therapeutic array and others have no perceived palliative benefit. With uncertainty in benefit, patient-focused care is the deciding factor. This information may serve as a point of reference for individual practice and to improve care of dying patients and identifies key areas where a better understanding of the role of particular types of medications in the palliative setting is needed.

UNMET NEED FOR EYE CARE TREATMENT AMONG OLDER PERSONS WITH DIABETES IN FREE-FOR-SERVICE AND MANAGED MEDICARE. A. E. Brown, L. Jiang, D.S. Fong, A.L. Coleman, P.P. Lee, C.M. Mangione, University of California, Los Angeles, Los Angeles, CA, Kaiser Permanente Southern California, Pasadena, CA, Duke University, Durham, NC (Tracking ID #76841)

BACKGROUND: Older persons with diabetes are at risk for undertreatment of eye diseases such as diabetic retinopathy, cataracts, and glaucoma, particularly when there are administrative or financial barriers to seeing an eye care specialist. Compared to fee-for-service (FFS), managed care (MC) settings may enhance coordination of eye care for persons with diabetes, but some managed care practices may limit access to specialty eye care.

METHODS: We studied a random sample of MC and FFS community-dwelling Medicare beneficiaries over the age of 65 years who lived in the same zip codes in Los Angeles County. All patients had been in the same system of care for >18 months. The MC participants were enrolled in one of 11 provider groups that contracted with the same for-profit network-model Medicare managed care plan. Information on individual characteristics was obtained through patient survey. Three trained ophthalmologists masked to the patient’s system of care performed the dilated eye exams and rated the need for urgent care (e.g. for elevated intraocular pressure or retinal detachment) or nonurgent care (e.g. new glasses or cataract removal) over the next 6 months. To evaluate the association between system of care and need for treatment, we constructed hierarchical regression models adjusted for age, sex, race/ethnicity, income, education, health status, supplemental insurance, duration of diabetes, and a visit to an endocrinologist or eye specialist in the prior year.

RESULTS: We report on 418 persons with diabetes (65% response rate). MC and FFS respondents reported similar rates of dilated eye exams in the prior year (83% vs. 80%, p = 0.59) and similar rates of preexisting eye diseases, but were significantly less likely to have had dementia and PEG tube placement (diagnosis of dementia had to precede PEG tube placement).

RESULTS: Mean age of patients with dementia and PEG (n = 6,836) increased from 74.6 years in 1990 to 77.8 years in 2001. Commonest comorbidities were cerebrovascular disease (60.02%), hypertension (18.59%), pneumonia/aspiration pneumonia (57.47%), and malnutrition (72%). Contrary to literacy reports, we found that number and rate of PEG tubes placed in demented veterans nationally has decreased since 1997. Although PEG tube placement initially rose sharply, it peaked in 1996 (n = 266, rate = 1.17%; 1996 n = 753, rate = 1.83%), and has decreased since, almost returning to the rate recorded in 1990 (2001: n = 445, rate = 1.2%). Additionally, we found that the rate and the change that occurred over time in the use of this procedure for dementia patients differ significantly by race/ethnicity. During every year of this study the rate of PEG tube placement in African Americans exceeded that in Whites (RR in 1990: 1.45, p = 0.031, RR in 2001: 1.97, p = 0.001), and the racial/ethnic disparity in the use of the procedure continues to the present. A logistic regression model showed that race and year affected PEG tube use in dementia patients (p = 0.001), and that there was a race by year interaction (p = 0.002). The risk of receiving a PEG tube did not change at the same rate between black and white patients throughout the years.

CONCLUSION: Decision-making for end-of-life care for patients with advanced dementia seems to have changed during the last decade, with a reduced use of PEG tube feeding for these patients. However, the striking and increasing racial/ethnic disparities in PEG-tube use for dementia patients raise concerns about the decision-making process, and the quality of end-of-life care for minorities.
Abstracts

EDUCATIONAL DISADVANTAGE AS A BARRIER TO FUNCTIONAL RECOVERY AFTER HIP DYSPLASIA IN/pOLDER PERSONS. P. M. C. medlin1, R. I. honk1, S. K. Inouye1 /Yale University, New Haven, CT (Tracking ID #75855)

BACKGROUND: While it is known that low education is associated with worse health, little is known about whether level of formal education affects recovery from illness. Seventy-five percent of older adults develop functional disabilities after hospitalization, increasing their risk of re-hospitalization, institutionalization, and death. The primary objective of this study was to assess whether education remained independently associated with functional recovery, even after controlling for other important biological and psychological factors that are presumed to be the pathways that convert social advantage into better health outcomes.

METHODS: We used data from a prospective cohort of subjects at least 70 years of age who were inpatients on the general medicine service at Yale New Haven Hospital between 1995 and 1998. Low education was defined as completion of less than high school. Covariates included race, age, sex, baseline functional and cognitive impairments, social support, depression, self-rated health, Charlson and APACHE II scores. The outcome was functional decline, defined as a seven Activities of Daily Living (ADL) score that was lower at six months than at one month before hospitalization. People who died after discharge were also considered to have declined.

RESULTS: The mean age of the study participants was 80 years (standard deviation 6.4 years), 60% were female, and 87% were white. Thirty-five percent of the cohort were dependent in at least one of the ADLs one month prior to admission. Of the 882 men and women in the cohort, 41% experienced ADL decline (N = 353) or death (N = 127) at 6 months. Using binomial regression, we predicted the association of education (GPA) with the adjusted relative risk (RR) for low education was 1.34, 95% confidence interval (CI) 1.14–1.58. With the addition of demographic factors (race, age, gender), the association of low education with the outcome was relatively unchanged, with RR 1.36, 95% CI 1.16–1.60. The further addition of functional (functional and cognitive) measures brought the RR to 1.23, 95% CI 1.04–1.46. When psychosocial factors (depression and social support) were added to the model, the RR was 1.27, 95% CI 1.07–1.49. The addition of clinical features (self-rated health, Charlson and APACHE II scores) minimally changed the association of education with the outcome (RR 1.26, 95% CI 1.00–1.59).

CONCLUSION: Educational disadvantage is associated with poor functional recovery after hospitalization in older adults. The association is clinically important, statistically robust, and only modestly affected by the additional consideration of other important biological and psychological factors.

PROVIDING SELF-MANAGEMENT EDUCATION AND SUPPORT TO VULNERABLE ELDERLY ACCORDING TO GUIDELINES: IS IT FEASIBLE? O. D. Clark1, S. R. Counsel1, C. M. Callahan1, T. E. stump1, A. B. Butler2, K. S. Bowden1, G. D. Ricketts1, Indiana University School of Medicine, Indiana University Center for Aging Research, Regenstrief Institute, Inc, Indianapolis, IN; Regenstrief Institute, Inc., Indiana University Center for Aging Research, Indianapolis, IN; "Wishart Health Services, Indianapolis, IN (Tracking ID #76247)

BACKGROUND: Data from our team-based intervention study to improve diagnosis and treatment of common geriatric syndromes among low-income older adults provided an opportunity to explore the challenges of self-management education and support in primary care. Our objective is to determine the frequency of care recommendations requiring self-management education and support and explore patient resources/barriers for implementation of these recommendations.

METHODS: We captured sociodemographic and baseline health status data on 107 intervention patients by telephone interview. Geriatrics team recommendations based on published guidelines were documented using a web-based care management application.

RESULTS: Study patients had a mean age of 72 years (range 65–92), 61% were African-American, and 78% were women. Out of 111 total care recommendations, 48 would require initial and 63 ongoing self-management education and support from the primary care provider. In the first 6 months of the intervention, patients had an average of 10 initial and 20 ongoing care recommendations. With an average of 3 physician visits over a 6-month period, self-management education and support at each visit would require attention to 10 initial and 20 ongoing recommendations. In regard to patient resources and barriers, baseline data showed that 82% reported <$10,000/year household income, 14% less than 8 years of education, 10% vision too poor to read a newspaper, 52% hearing impairment, 20% clinical depression, and 48% lived alone. At least moderate interference with normal activities was reported by 38% of patients due to physical or emotional problems, and 45% due to pain. One of 3 patients reported regular assistance from a friend or neighbor and nearly 9 of 10 had access to a person in case of need. In the six months prior to intervention, 19% reported a social worker visit and 3% a home health visit.

CONCLUSION: Among lower income older adults, self-management education and support demands of primary care providers are substantial. With considerable barriers and limited resources, lower income older adults’ needs in education and support of self-management recommendations are unlikely to be met under the current health system.

PULSE PALPATION IS NOT A SENSITIVE SCREENING TOOL FOR PERIPHERAL ARTERIAL DISEASE. T. C. Collins1, N. J. Peterson1, M. E. Suarez-Almazor2; Baylor College of Medicine, Houston, TX (Tracking ID #75481)

BACKGROUND: Pulsed pulse palpation is often the initial screen to determine the presence of arterial occlusions of the lower extremities. We seek to determine the role of pulse palpation in the diagnosis of peripheral arterial disease when compared to the more sensitive and underutilized screening tool, the ankle-brachial index.

METHODS: We screened patients 50 years and older for PAD within three primary care clinics located in the Houston Health Care System and the Harris County Hospital District (Houston, TX). PAD was diagnosed by an ankle-brachial index (ABI), the ratio of the systolic blood pressure in the ankle to the systolic blood pressure in the arm) of <0.9. At each visit, pedal pulse (i.e., dorsalis pedis and posterior tibial) palpation was performed for each leg. Of