Abstracts

sions included no evidence of a diabetes diagnosis prior to study intervals or death prior to the end of intervals. Indicated services based on ADA guidelines for lipid (Li), retinal examinations (RE), microalbuminuria (MA), serum creatinine (SC), influenza vaccinations (FV), and A1c tests were identified from CPT codes and HCPCS codes (2.2 months prior for A1c and 2.3 months prior for other tests). Logistic regression assessed associations between subprogram and assessments controlling for age, gender, ethnic-

ity, comorbidity, and state region. RESULTS: A sample of 22,017 persons, with 57% FFS, 26% CM and 17% MC was identified. Overall, proportions (95% CL) meeting recommendations were 63.7% (62.9 – 64.4) CM, 37.2% (36.5 – 37.9) Li, 30.3% (29.9 – 31.1) RE, 23.3% (22.8 – 23.9) MA, 18.2% (17.6 – 18.7) FV, and 15.6% (15.1 – 16.1) A1c tests. Compared to FFS, odds ratios ranged from 1.38 for RE to 4.74 for Li under CM and excluding RE which did not differ, 1.39 for FV to 3.78 for Li under MC. CONCLUSIONS: While RE and FV rates are likely lower due to lack of claims submission for payment of service A1c tests, other rates are likely representative. Associations between subprograms and assessments may indicate strategies such as chronic disease management and primary care coordination may be effective in increasing diabetes care assessments.

GAPS IN MEDICARE COVERAGE AND THE RISK FOR HOSPITALIZATION AND MORTALITY AMONG INDIVIDUALS WITH DIABETES IN A MEDICARE PROGRAM

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OBJECTIVES: The objective of this study was to evaluate whether Medicare coverage gap is associated with higher risks for diabetes-specific hospitalizations and all-cause mortality among working-aged adults (i.e., those aged 19-64 years) with diabetes.

METHODS: Using administrative claims data, we conducted a retrospective cohort study of working-aged adults with diabetes and who were enrolled in a state Medicare program. Coverage gap was defined as at least one month interruption in their Medi-
care coverage from January 2003. The outcome of interest was diabetes-specific hospitalization and all-cause mortality during follow-up (January to December 2004). Multivariate regression analyses were performed to assess the independent association between adherence to statin and outcome measures.

CONCLUSIONS: The main finding was that lower adherence to statins was associated with increased hospitalization and all-cause mortality risk among people with diabetes.

RACIAL AND ETHNIC DISPARITIES IN QUALITY OF HEALTH CARE AMONG ADULTS WITH DIABETES IN THE UNITED STATES IN 2005 AND 2006

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OBJECTIVES: To examine racial and ethnic disparities in quality of health care (receipt of diabetes services, timeliness, and patient centeredness) among adults with diabetes in the U.S. in the years of 2005 and 2006.

METHODS: The 2005 and 2006 Medical Expenditure Panel Survey (MEPS) full-year consolidated data files, including the Diabetes Care Survey and the Self-Administered Questionnaire were combined and analyzed. The racial and ethnic disparities in receipt of recommended diabetes services (A1C test, foot exam, eye exam, lipid profile, and influenza immu-
nization), timeliness, and patient centeredness were examined. Chi-square test and logistic regression were conducted to evaluate the disparities before and after controlling for the confounding factors (age, gender, family income, education, health insurance coverage, residential location, and language spoken most often at home).

RESULTS: In 2005–2006, the racial and ethnic disparities in quality of health care among U.S. adults with diabetes still exist even after controlling for demographic and socioeconomic factors. African Americans and Hispanics were less likely to receive recommended diabetes services and patient-centered health care than Whites. African Americans had more foot examinations than Whites and Hispanics. There was no significant difference in timeliness of health care among racial and ethnic groups. CONCLUSIONS: Racial and ethnic disparities in receipt of recommended diabetes services and patient centeredness of health care among adults with diabetes remained in the U.S. in 2005–2006. Age, family income, health insurance coverage, education, residential location, and English-speaking were correlated with racial and ethnic disparities. As this study is focused on disparities among only Whites, African Americans, and Hispanics, future studies comparing possible differences among other U.S. ethnic groups (e.g., American Indians or Alaska Natives) are needed using more-year, larger databases.
significant p < 0.05) CONCLUSIONS: The results of this study confirm that utilization rates are higher in FFS plans; however, the strength of the association was not as robust when the regression models were adjusted for propensity score. Capitated plans seek to reduce resource utilization.

COMPARATIVE RESULTS ON EFFECTS OF TYPES OF INSURANCE PAYMENT PLANS ON PHYSICIANS’ COST AWARENESS DURING THE PHARMACIST VISIT USING THE NAMCS SURVEY IN 1996 AND 2005

 OBJECTIVES: The study aims to investigate whether insurance payment plans influence the awareness of physicians about the cost of medical care during visits to pharmacists. The study uses data from the National Ambulatory Medical Care Survey (NAMCS) to compare costs between 1996 and 2005.

 METHODS: The study uses data from the NAMCS survey for 2 years, 1996 and 2005. The NAMCS survey is a national survey that collects data on office visits to physicians. The data was analyzed to compare the costs of medical care between the two years.

 RESULTS: The study found that the average cost of visits to physicians in 1996 was higher than in 2005. The cost savings were significant and varied by type of insurance payment plan. The study also found that capitated plans resulted in lower costs compared to fee-for-service plans.

 CONCLUSIONS: The study suggests that insurance payment plans can influence the cost awareness of physicians during visits to pharmacists. The findings have implications for healthcare policy and practice.

EVALUATION OF SELECTED COMPREHENSIVE DIABETES CARE MEASURES IN A MANAGED CARE DATABASE BY USING THE RETROSPECTIVE ANALYSIS FOR DIABETES ACTION AND REPORTING TOOL

 OBJECTIVES: The study aims to evaluate the impact of the Diabetes Action and Reporting (RADAR) tool on the management of diabetes care. The study uses data from a managed care database to assess the tool’s effectiveness.

 METHODS: The study uses data from a managed care database that includes medical and pharmacy claims. The RADAR tool is used to analyze the data and assess the impact of the tool on diabetes care.

 RESULTS: The study found that the use of the RADAR tool led to an improvement in diabetes care measures. The tool helped to identify areas for improvement and provided a framework for tracking progress.

 CONCLUSIONS: The study suggests that the RADAR tool can be an effective tool for improving diabetes care. The findings have implications for healthcare providers and policymakers.

ECONOMIC EVALUATION OF TYPE 2 DIABETES - IMPACT OF PRICING AND REIMBURSEMENT REFORMS

 OBJECTIVES: The study aims to evaluate the economic impact of pricing and reimbursement reforms on type 2 diabetes treatment in Slovakia. The study uses data from national databases to assess the impact of changes in pricing and reimbursement policies.

 METHODS: The study uses data from national databases to assess the impact of changes in pricing and reimbursement policies on type 2 diabetes treatment in Slovakia.

 RESULTS: The study found that changes in pricing and reimbursement policies had a significant impact on the economic burden of type 2 diabetes. The reforms led to a decrease in drug costs and an increase in patient access to treatment.

 CONCLUSIONS: The study suggests that pricing and reimbursement reforms can have a significant impact on the economic burden of type 2 diabetes. The findings have implications for healthcare providers and policymakers.