these hospitalizations, and in 26.4% of patients. Among all hospitalizations, not having an HbA1c test in the previous 3 months had a twofold increase in death rate (32.4% vs 16.2%), and hospitalization without glucose-monitoring values of 200 mg/dl or greater had a higher rate (27.7%) than did those with lower glucose levels (18.3%). Endocrinologist treatment during a hospitalization was associated with a higher HbA1c utilization rate (43.6%) compared to treatment from all other specialists. A word review included histories of patients, younger patients had a higher HbA1c utilization rate than did patients > 65 years (47.2% vs 29.5% 21-64, and 23.8% 65+), as did male patients (28.3% vs 24.5%). Type 1 diabetics had a higher rate than did patients with pre-diabetes/undiagnosed diabetes (41.6% vs 24.7%). Type 2 diabetes patients had a utilization rate of 44.3%. Among hospitalizations of pre-diabetes/undiagnosed patients who received an HbA1c test, 17.9% had values of 6.5% or greater. CONCLUSIONS: These data suggest that overall utilization of HbA1c tests in the hospital setting is low among pre-diabetic/undiagnosed and diabetic patients with hyperglycemia. The utilization rate differs significantly by patient characteristics and by physician specialty. These data highlight the potential for improved identification and diagnosis of diabetes within the hospital setting.

PHSV4
INFORMATION OF CNS SPECIALISTS IN HEALTH CARE PROVISION FOR PATIENTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD): NEW DATA FROM NORDBADEN, GERMANY, 2003 - 2009
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OBJECTIVES: In our earlier cross-sectional analyses of physician involvement in health care provision for patients with a diagnosis of ADHD (for year 2003), we observed that children and adolescents treated by a CNS specialist had 33.5% of adult patients been seen by a CNS specialist. The present study revisits health care provision for ADHD patients by physician group. METHODS: Patient-level data were extracted for analysis from the physician-centered claims database of the Kassenärztliche Vereinigung (KV) in Nordbaden / Germany, which covers the entire regional population enrolled in statutory health insurance (>2.3 million lives). For calendar year 2009, 21,287 patients with ADHD [“hyperkinetic disorder”, HKD; ICD-10 codes F90.0 or F90.1] with coexisting conduct disorder (HKCD; F90.1 or a combination of F90.0 and F91) were available for analysis of health care provider contacts. RESULTS: Overall, the rate of ADHD patients seen at least once by a CNS specialist (physician) increased from 42.0% in 2003 to 49.1% in 2009; the rate of those seen at least twice during the calendar year increased from 26.4% to 33.2% (for age group 0-5 years, 9.1% to 11.1%, 6-12 years, from 27.4% to 33.7%, 13-17 years, from 30.3% to 33.1%, 18+ years, from 26.4% to 33.2%. Patients with HKCD were more likely to be seen by CNS specialists than patients with HKD only. Most children (in 2009, 84.4%) and adolescents (61.0%) were seen at least once by a pediatrician. The rate of patients seen by psychotherapists remained stable at ~10%. Within provider groups, health care for patients with ADHD was highly concentrated. Each child and adolescent psychiatrist treated, on average, 231 patients with ADHD. CONCLUSIONS: Despite a moderate increase since 2003, CNS specialist involvement in health care provision for patients with ADHD remains relatively low.

PHSV5
THE SUICIDALITY IN THAI POPULATION: A NATIONAL SURVEY
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OBJECTIVE: To develop an off-the-shelf catalogue of quality improvement (QI) interventions to implement in preventing hospital-acquire pressure ulcers (HAUs). In 2007, the Institute of Healthcare Improvement (IHI) released a 17-item best-practice framework of general QI interventions organized into four domains of hospital practice: Leadership; Staff; Information & Information Technology; and Performance & Improvement. Since HAU prevention has become a burgeoning international topic because of its monetary burden on health care, clinicians have investigated novel methods to bolster HAU prevention guidelines. QI interventions are a promising resource for improved HAU outcomes. METHODS: Starting with the IHI best-practice framework, fourteen leading experts in QI and HAU prevention at academic tertiary care facilities were interviewed in-person to qualitatively augment the list of QI interventions to reflect HAU-specific preventive QI interventions. The respondents possessed backgrounds as physicians (6), wound care nurses (4), QI experts (2), and outcomes researchers (2). Interviews followed a structured outline of the best-practice framework, in which they were allowed to add, delete, or modify QI interventions within each domain as they pertained to HAU prevention.

RESULTS: The series of qualitative interviews resulted in successful augmentation to IHI’s best-practice framework of QI interventions to more accurately reflect current practice in HAU prevention. The HAU-practice framework contains seven Leadership items, six Staff items, four Information & Information Technology items, and eight Performance & Improvement items. These items were further evaluated by two quality improvement experts. One-fifth of items were removed from the原始 framework, twelve were added, and all remaining items were modified in some manner. CONCLUSIONS: This qualitative study provides an off-the-shelf catalogue of QI interventions that wound care teams can use for prevention of HAUs and possibly other pressure injury conditions. For further consideration, the field would benefit from comparative effectiveness research about QI interventions and strategies for HAU prevention that hospitals can then focus their efforts toward.

PHSV6
CLINICAL CHARACTERISTICS, TREATMENT PATTERNS, AND RESOURCE UTILIZATION IN A REAL-WORLD EUROPEAN POPULATION WITH DIVERTICULITIS
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OBJECTIVES: We documented the clinical characteristics, treatment patterns, and resource utilization associated with diverticulitis in a real-world European population. METHODS: Data were abstracted from medical charts of 1,509 patients in 5 countries (300 per country). UK, Germany, France, The Netherlands, and Spain. Inclusion criteria were: diagnosed with diverticulitis during January 1, 2007–September 30, 2010, aged ≥18 years at first (index) diagnosis, no history of colon cancer, not enrolled in diverticulitis-related clinical trial, and ≥12 months of chart history. RESULTS: Index diagnosis was evaluated by over all available post-index follow-up (≥12 months). RESULTS: Mean (SD) age at index was 61.7 (11.2) years and 55% of patients were male. Diagnosis setting was evenly distributed by general practitioner (29%), specialist, (24%), emergency (24%), and hospital (22%). For index case, the most common chronic disease (27%) was hypertension and 20% of patients were considered obese. More than half of patients presented with or subsequently developed diverticulitis-related complications, most commonly fissure, abscess, fistula (23%) or lower gastrointestinal (GI) hemorrhage (14%). Peritonitis, a life-threatening infection, was seen in 8.4% of patients. One-fifth (20%) of patients did not receive antibiotics or other pharmacotherapies (e.g., aminosalicylates, analgesics, other GI drugs) used to manage diverticulitis and its symp-