

OBJECTIVES: Provider continuity is defined as seeing the same health care provider over time. Previous studies indicated that high provider continuity improves health care outcomes and the efficiency of health care delivery. The impact of provider continuity in sickle cell disease (SCD) care, however, is unknown. This study examined the association between provider continuity and the risk of SCD-related hospitalization and re-hospitalization within 30 days of discharge. **METHODS:** A retrospective cohort study was conducted using Florida Medicaid claims data from 2001-2005. Patients with claims containing SCD-related ICD-9 codes (282.41-282.42, 282.6-282.64, 282.68-282.69) were selected. To be eligible, individuals had to be aged <65 years, continuously enrolled in Medicaid, and have made ≥ 2 ambulatory visits. Modified modified continuity index (MMCI) scores were calculated to quantify provider continuity. Cox proportional hazard modeling was used to examine the relationship between MMCI and hospitalization and 30-day re-hospitalization controlling for basic demographics, prior utilization, SCD treatments and complications. **RESULTS:** A total of 2422 patients with mean age of 10.2 (SD=11.9) and 47.2% male were included. Average MMCI score was 0.60 (SD=0.28), 53.47% had ≥ 1 SCD-related hospitalization; of those, 18.8% were re-hospitalized within 30 days. After controlling for patient-level factors, patients with higher provider continuity were less likely to be hospitalized (HR=0.53, 95% CI: 0.44-0.65), but MMCI was not significantly associated with 30-day risk of re-hospitalization (HR=0.89, 95% CI=0.55-1.43). **CONCLUSIONS:** Higher provider continuity was associated with a lower risk of SCD-related hospitalization in the Florida Medicaid SCD population, but did not affect the rate of 30-day re-hospitalization. Policies that improve and maintain continuity between SCD patients and a single provider may lead to lower hospitalization rates and possibly lower health care costs.

PSY71

HEALTH AND FUNCTIONAL STATUS FOR INDIVIDUALS WITH THROMBOCYTOPENIA IN THE UNITED STATES: EVIDENCE FROM NHANES

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OBJECTIVES: Thrombocytopenia, or low blood platelet count, is associated with disease progression and treatment for several chronic conditions, including liver disease, cancer, and HIV. Yet, little information describing the impact of thrombocytopenia on patients is available. This study compared indicators of health and functional status among individuals with and without thrombocytopenia. **METHODS:** 1999-2008 National Health and Nutrition Examination Survey (NHANES) data were used to identify individuals aged ≥ 20 years with normal and low platelets, using a threshold of $150 \times 10^9/L$. Indicators of health and/or functional status included self-reported general health [1-5 scale, 1=excellent], number of health care visits and overnight hospital stays, days physical health was not good, inactive days due to physical health, and work limitations. Weighted means and frequencies were summarized and compared using paired t-tests and chi-squared tests, respectively. **RESULTS:** 22,959/25,772 participants aged ≥ 20 years had information on platelets. Of these, 526 (1.9%) had low platelets at the time of examination. Individuals with thrombocytopenia were older (51.7 vs 37.2 years) and more likely to be male (67.7% vs 48.6%), infected with hepatitis C (7.4% vs 1.4%), and ever diagnosed with cancer (14.2% vs 8.0%) or a liver condition (12.3% vs 3.1%), $p < .05$ for all. Fewer participants with thrombocytopenia reported excellent health compared to those with normal platelets (12.5% vs 16.5%, $p < .0001$). Participants with thrombocytopenia reported more health care provider visits (2.35 vs 2.02, $p < .0001$) and were more likely to report an overnight hospital stay (0.19% vs 0.11%, $p < .001$). Participants with thrombocytopenia had more inactive days due to physical health and were more likely to face work limitations ($p < .01$ for all). **CONCLUSIONS:** Thrombocytopenia is associated with limitations on functional status and increased health care utilization, some of which may be related to patients' underlying health conditions. Further study is needed to determine the incremental impact of thrombocytopenia.

PSY72

VARIATION BY AGE IN HEALTH-RELATED QUALITY OF LIFE OF PATIENTS INITIATING TREATMENT FOR MYELODYSPLASTIC SYNDROMES

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OBJECTIVES: Minimal health-related quality of life (HRQOL) data have been published on myelodysplastic syndromes (MDS) patients in the United States. This analysis characterized HRQOL by age group of MDS pts treated with Vidaza® in the AVIDA® registry. **METHODS:** Data were collected from AVIDA, a Vidaza treatment registry, initiated in US community clinics. Clinicians provided patient demographic, treatment pattern, and clinical outcome data. Patients reported HRQOL (EORTC-QLQ-C30) within 2 months of treatment initiation. Mean (Standard Deviation [SD]) scores on global health status (GHS), 5 functional scales and 9 symptom/other scales were analyzed by age: <65, 65-74, ≥ 75 years. Statistical significance was ascertained by ANOVA using SAS 9.1. **RESULTS:** Data were reported from 99 clinics on 427 pts: <65 (n=68), 65-74 (n=127), and ≥ 75 (n=232) years. Mean (SD) GHS was 54.8 (1.2) overall, and similar among age groups: 53.9 (2.7), 54.7 (2.1), and 55.2 (1.6), $p = 0.9263$. Similarly, physical, role, and social functioning were comparable. Emotional and cognitive functioning, however, were worse among those <65 versus the older groups: 66.2 (3.5), 78.6 (1.8), 79.5 (1.5), $p < 0.0001$ for emotional, and 72.4 (3.5), 82.7 (1.7), 80.3 (1.4), $p = 0.0067$ for cognitive. The <65 cohort reported significantly worse scores on 4 of 9 symptom/other scores: financial difficulties (34.8 (4.5),

15.3 (2.4), 13.0 (1.7), $p < 0.0001$; insomnia (39.7 (4.0), 27.5 (2.7), 27.3 (2.2), $p = 0.0141$); appetite loss (29.9 (3.8), 18.4 (2.5), 25.3 (2.1), $p = 0.0263$); and fatigue 53.9 (3.1), 44.3 (2.3), 48.5 (1.8), $p = 0.0452$). **CONCLUSIONS:** AVIDA registry findings indicate baseline HRQOL among MDS patients in real world settings differs by age in certain domains. Findings suggest HRQOL is similar or better in elderly MDS patients than younger patients. These differences in emotional and cognitive functioning, fatigue, insomnia, appetite loss, and financial difficulties require consideration by clinicians in managing MDS patients.

PSY73

PAIN MEDICATION USE AND DETERMINANTS OF OPIOIDS PRESCRIBING IN THE UNITED STATES OUTPATIENT SETTINGS

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OBJECTIVES: Chronic pain is a major public health concern in the US. Established guidelines are available for management of non-malignant chronic pain, including opioid use. However, discrepancies in opioid prescribing patterns due to physician misconceptions remain concerning. Therefore, this study evaluated pain medication use and investigated determinants of opioid analgesic prescribing in the US outpatient settings for common non-malignant chronic pain indications. **METHODS:** This cross-sectional study analyzed the National Ambulatory Medical Care Survey (NAMCS) data from 2002-2007 on patients 18 years and older with non-malignant chronic pain diagnosis based on ICD-9-CM codes identified as reason for visits. Pain medications prescribed were retrieved using NAMCS drug codes. Multivariate logistic models examined determinants of opioid prescribing among chronic pain patients. **RESULTS:** Approximately 69 million weighted outpatient visits were reported for non-malignant chronic pain between 2000-2007 in the US. The mean age for patients was 53 (range 18-100) and the majority were women (63%). Neuropathic pain was reported for 2.39% visits while 16.24% had an inflammatory pain diagnosis. Non-medication treatment was prescribed during 26% of these visits. While most (95%) visits reported prescribing NSAIDs, 29% reported receiving prescriptions for more than five medications. Primary care physicians (PCPs) were 1.74 times more likely to prescribe opioids (OR(odds ratio):1.74, CI:1.42-2.14) than other specialty physicians. Patients receiving more than five medications were 2.80 times more likely to receive opioids (OR:2.80, CI:2.28-3.44) than those with less than five medications. Patients from the southern region of the US were 1.43 times more likely to receive opioids (OR:1.43, CI:1.06-1.94) than patients from the northeast region. **CONCLUSIONS:** According to our study, visits with PCPs, more than five prescriptions, established patients, and physician visits in the southern region of the US were some of the determinants of opioid prescribing. Increased awareness of opioid prescription guidelines for pain management may eliminate prescription discrepancies and improve patient care.

PSY74

TREATMENT CHOICE FOR PAIN MANAGEMENT IN NURSING HOME HOSPICE/PALLIATIVE CARE RESIDENTS IN THE UNITED STATES

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OBJECTIVES: This study determined factors associated with treatment choice for pain management in US nursing home hospice/palliative care residents. **METHODS:** This is a cross sectional study of data from the resident file of the 2004 National Nursing Home Survey (NNHS). Residents assigned to a bed in a hospice specialty unit or receiving services from a special program for hospice/palliative care in 1174 systematically selected nursing homes and having pain in 7 days before the survey were included. Treatment choices included standing order (SO) of analgesics, as-needed orders (PRN) of analgesics and non-pharmacological treatment (NPT). Factors evaluated were gender, marital status, age, ethnicity, eating limitation, toilet limitation, urinary incontinence and bowel incontinence. Weighted descriptive analysis, bivariate analysis using chi-square tests and multivariate analysis using logistic regression were conducted using SAS version 9.2 to determine factors associated with pain management. **RESULTS:** Overall 22.6% (338,029/1,492,207, weighted) patients met the study inclusion criteria. Mean[SD] age was 79.1[13.3] years, 74.7% were females and 89.8% were white. 78.6%, 49.8%, and 29.3% received PRN, SO, and NPT, respectively. Logistic regression showed higher likelihood to receive SO for patients of age at or above 65 years (OR=1.51 95% CI=1.184-1.948 $P = 0.001$), patients with bowel incontinence (OR=1.21 95% CI=1.020-1.437 $P = 0.028$) and Medicaid patients (OR=1.5 95% CI=1.258-1.799 $P < 0.0001$). Likelihood to receive PRN was lower for patients of age at or above 65 years (OR=0.60 95% CI=0.428-0.841 $P = 0.0031$), patients with bowel incontinence (OR=0.67 95% CI=0.533-0.859 $P = 0.0014$), Medicaid patients (OR=0.65 95% CI=0.525-0.806 $P < 0.0001$) and Hispanics (OR=0.327 95% CI=0.204-0.527 $P < 0.001$). Likelihood to receive NPT was higher for patients with toileting limitation (OR=2.905 95% CI=1.135-7.434 $P = 0.026$) and lower for patients with urinary incontinence (OR=0.022 95% CI=0.003-0.172 $P = 0.0003$). **CONCLUSIONS:** Factors affecting treatment choice were age, bowel and urinary incontinence, toileting limitations, ethnicity and insurance type and can be targeted in future studies aiming at management of pain in nursing homes.

Systemic Disorders/Conditions – Research on Methods

PSY75

PREVALENCE RATIOS AGAINST ODDS RATIOS AS EFFECT MEASURES IN A CROSS-SECTIONAL STUDY OF OBESITY AND ITS CHRONIC COMORBID CONDITIONS

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