To examine the relationship between payer status and potential confounders on DAMA using the National Hospital Discharge Survey. METHODS: Retrospective analysis of a random, nationally representative sample of inpatient discharges in the US from 2004 to 2006. Patients represent discharges from short-stay hospitals in the US. Newborns and patients with an undefined payer status were excluded. Only patients with a routine or DAMA discharge status were included. A logistic regression analysis was performed modeling DAMA versus routine discharge as the outcome variable, with payer status as the primary predictor, and confounder variables, including gender, race, marital status, hospital type, geographic region, admission type and source, and drug abuse/addiction. Logistic regression analysis was also performed after removing drug/alcohol abuse/addiction patients. RESULTS: From 2004 to 2006 DAMA accounted for 1.23% (n = 946,232) of all hospital discharges when drug and alcohol abuse/addiction patients are included and 0.76% (n = 510,156) when excluded. Controlling for the confounder variables, public (AOR = 0.72, 95% CI = 0.61-0.80) and privately (AOR = 0.46, 95% CI = 0.40-0.52) insured patients are significantly less likely to DAMA than self-pay patients. Consistent with the literature, males, African-Americans, private hospitals, emergency admissions, and drug (AOR = 4.57, 95% CI = 4.22-4.96) and alcohol (AOR = 5.00, 95% CI = 4.46-5.61) abuse/addiction are significant risk factors for DAMA. Many of these relationships become stronger when substance abuse cases are excluded. CONCLUSIONS: Considerable evidence exists that initiatives may be needed to better manage self-pay patients and ensure they do not DAMA. Further research should be done with longitudinal data to examine the relationship between DAMA and health outcomes. Prior research indicates that DAMA predictors may also be responsible for non-compliance of prescribed drug therapy, especially following discharge. Therefore the potential for early pharmacist involvement has also been identified.

HOW DO MANAGED PHYSICIAN PANELS COMPARE AGAINST NON-PANEL PHYSICIANS FOR THE PURPOSE OF RESEARCH? Narayanan S TNS Healthcare, New York, NY, USA

OBJECTIVES: Clinical investigator databases, prescriber and ad-hoc sources often constitute the physician pool for epidemiological and outcomes-research initiatives. Use of “managed physician panels” for such research purpose is not yet common. This study aims to compare demographics, prescribing patterns and attitudes/opinions between physicians in “managed panels” and free-bound non-panel sample in the U.S. METHODS: TNS manages 3-Street Panel, a managed panel of over 23,000 practicing physicians in the U.S across 35 specialties. A small proportion of these physicians, especially allergists/pulmonologists, were recruited online, and another cohort from free-bound (non-panel) sample was recruited via telephone for a research initiative. Practical characteristics, treatment dynamics and attitudes/opinions were measured in both cohorts using a standardized 30-minute survey; the results were analyzed to assess any statistical difference between the panels and non-panels across the measured domains. RESULTS: Survey results from allergists/pulmonologists (83 panels & 88 non-panels) specifically in the COPD/Asthma categories were assessed. There were no statistically significant differences observed between the cohorts in practice characteristics: percent of time spent in clinical practice, number of COPD and/or Asthma patients seen in a typical month, percent of COPD patients with COPD and/or Asthma, and percent of patients with COPD with quality of asthma and CO2 disorders. CONCLUSIONS: This is one of the first studies to quantitatively compare managed panel of physicians to their non-panel counterparts in the U.S and the results showed no statistical differences between the cohorts in the measured domains. Managed panels are viable options for scientific research studies, as they provide robust, cost-effective, quick sample of physicians, with relatively high response rate.

PATIENT PRIVACY AND DATA CONFIDENTIALITY AND THE USE OF SECONDARY DATA

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OBJECTIVES: No well-defined standards, including provisions in HIPAA, currently provide clear guidance for merging, linking, and analyzing secondary health data that were originally collected for patient care, such as electronic medical record (EMR) data. A literature review explored factors that may affect potential risks of secondary data research from the perspective of patient privacy and data confidentiality. METHODS: The PubMed database and internet sites of CDC, DHHS, and patient advocacy groups were searched to identify publications from January 1, 1998 to March 7, 2008 involving patient privacy and secondary use of data. Search terms included (but were not limited to): confidentiality, privacy, consent, ethics, secondary data, secondary analysis, patient data, de-identified, and identifiable. RESULTS: A total of 33 documents were identified. Several discussion topics that address patient privacy within the context of secondary data research were identified in the literature. These issues were assessed and grouped into four domains: 1) concerns about inadequacy of patient consent [76% of articles] (eg, no patient consent is needed or that consent obtained for general research purposes may not be adequate for specific research hypotheses); 2) concerns about confidentiality of the data and the degree to which the data can be de-identified [38%]; 3) concerns about data access, including monitoring, controlling, and regulation of data access [85%]; and 4) concerns about the investigators’ objectives for analyzing and using the data [52%] (eg, epidemiology and surveillance studies caused less concern than did market research). CONCLUSIONS: We identified four recurrent themes in the ED they touched upon patient consent, confidentiality of data, data access, and research objectives. Dialogue about these issues between investigators, research oversight administrators and patient advocates may help clarify standards to ensure that secondary data research is broadly acceptable from a patient privacy and data confidentiality perspective.

ASSESSING THE EFFECT OF COST-SHARING ON EMERGENCY DEPARTMENT USE BY ECONOMICALLY DISADVANTAGED PERSONS

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OBJECTIVES: Emergency departments (ED) are designed to provide unexpected care for seriously ill and injured persons, but people may seek care in EDs for other reasons as well. In 2005, for example, 13.9% of ED visits in the United States were considered non-emergent. Non-emergent use of the ED contributes to increased health care costs and may indicate that access to health care is limited. The purpose of this project was to describe and elicit determinants of ED use in a sample of economically disadvantaged persons METHODS: We searched the published, English-language biomedical literature for articles on costs, cost-sharing, and ED use, for all years included in Medline, 1950 to the present. RESULTS: In 2005, of 115.3 million ED visits, 13.9% were considered non-emergent (requiring attention within 2–24 hours). In an analysis of data from 2000-2001, Hunt et al found that frequent (>4/year) ED use was positively associated with poor physical and mental health. However, al reported that ED copays in insured persons from $1 to $100 were associated with lower ED use, but not with poor outcomes. Wharam et al found that, from 2001–2005, higher deductible insurance was associated with decreased ED visits among persons with employer-based health insurance, but not with decrease in the odds for a first ED visit. CONCLUSIONS: Programs to decrease ED use, such as cost-sharing, have been evaluated, but studies to evaluate these types of policies have typically focused on insured individuals. As a result, there is an important gap in understanding the epidemiology and economics of ED use among low-income, uninsured, and underinsured persons.