THE EFFECTS OF NONCOMPLIANT COST-CUTTING BEHAVIORS ON OUTCOMES AMONG ADULTS IN THE UNITED STATES

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OBJECTIVE: To quantify the effects of noncompliant cost-cutting behavior on health-related quality of life (HRQOL), work productivity, and activity impairment among adults in the United States. METHODS: Data were from quarters one and two of the 2007 National Health and Wellness Survey (NHWS), an internet-based study of the health care attitudes, behaviors, disease states, and outcomes of a demographically representative sample of adults age 18+. Noncompliant cost-cutting behaviors were defined as taking less medication than prescribed, cutting tablets in half, or buying fewer tablets. Outcomes measures include the SF12V2 and the Work Productivity and Activity Impairment (WPAI) questionnaire. Linear regression analysis was used to control for gender, age, race, marital status, education, and comorbid conditions. RESULTS: Of the 42,010 NHWS respondents, 7% took less medication than prescribed, 6% cut tablets in half, and 2% bought fewer tablets. Controlling for potential confounders, SF12 physical and mental summary scores are significantly lower for those taking less medication (2.3 and 2.5 points lower, p < 0.001), those cutting tablets in half (0.9 and 1.1 points, p < 0.001), and those buying fewer tablets (1.5 and 1.6, p < 0.001). Controlling for potential confounders, WPAI overall work loss and WPAI activity impairment are significantly lower for those taking less medication (10.3 and 7.2 points lower, p < 0.001), those cutting tablets in half (11.2 and 5.3 points, p < 0.001), and those buying fewer tablets (15.8 and 8.2, p < 0.001). CONCLUSION: Noncompliant cost-cutting behavior negatively affects humanistic outcomes. By decreasing this behavior cost savings and compliance programs should have a positive effect on humanistic outcomes.
FDA safety communications related to highly prescribed products including the thiazolidinediones and bisphosphonates in 2007, information on drug safety was present weekly, if not daily, in the newspaper and on television. To assist consumers in understanding their risk of developing serious side effects and put into context the relative risk of their various medications, we have developed a 5-color drug risk rating system. METHODS: The iGuard Risk Rating system is a patented process for summarizing serious adverse events contained in each medication’s Prescribing Information. Specifically, we focus on: 1) the severity of the reaction (serious disability or death); 2) the likelihood of the reaction (e.g., >1 in 10,000); and 3) proportion of the population affected (e.g., 0–15%). We also adjust for lack of experience with a product on the market: <1,000,000 prescriptions or <2 years post-launch. Our iGuard Risk Ratings, from lowest to highest, are as follows: 1) Green: Low Risk=Suitable for widespread use; 2) Blue: General Risk=Use under normal care of a doctor; 3) Yellow: Guarded–Be on the lookout for safety events; 4) Orange: Elevated Risk–Create a personal risk reduction plan with your doctor; and 5) Red: High Risk—Requires careful consideration of risk versus benefit. RESULTS: To date, we have rated 106 medications. Risk Ratings associated with individual medications are available on the project website at www.i-guard.org. A total of 80 of 106 medications (75%) were rated Level 2/Blue: General Risk. An additional 20% were rated Level 4/Orange: Elevated Risk. Ratings across molecules within a therapeutic class are very similar. CONCLUSION: Consumer feedback on the iGuard Risk Ratings has been very positive, especially in understanding which of their medications they need to be most diligent in monitoring.

**PHP11**

**ETHNIC DISPARITIES IN HOSPITAL DISCHARGES AGAINST MEDICAL ADVICE AMONG CARDIOVASCULAR DISEASE PATIENTS:** THE ROLE OF HOSPITAL QUALITY

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OBJECTIVE: Ethnic disparities in hospital discharges against medical advice (AMA) have been examined in previous studies. However, the institutional factors affecting health decision making have received much less attention. This study examines the evidence for a joint impact of ethnicity and hospital quality on the likelihood of a discharge AMA in patients with cardiovascular disease (CVD). METHODS: Adult patients hospitalized with a primary admissions diagnosis of CVD from 2000 to 2005 were identified in a state-wide confidential inpatient hospital discharge dataset. The dataset was augmented with information from several sources, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A high quality hospital was defined as a hospital whose performance exceeded the state average on each JCAHO hospital performance measure. A hierarchical generalized linear logistic model of a discharge against medical advice (AMA) was estimated using cross-sectional data. RESULTS: A total of 2,593 of the 328,342 hospitalizations for CVD (0.8%) resulted in a discharge AMA. The patients self-identified as non-Caucasian in thirty percent (N = 100,074) of the hospitalizations. Fifteen percent (N = 48,177) of the hospitalizations occurred in high quality hospitals. The adjusted odds of a discharge AMA in a low quality hospital were lower for non-Caucasians (OR = 0.74; p = 0.0005) compared to Caucasians while the adjusted odds of a discharge AMA in a high quality hospital were unchanged between Caucasians and non-Caucasians (OR = 0.95; p = 0.6). Among Caucasians, a discharge AMA was less likely (OR = 0.75; p = 0.01) at a high quality hospital compared to a low quality hospital while, among non-Caucasians, the odds of a discharge AMA were unchanged (OR = 0.96; p = 0.74) across hospital quality groups. CONCLUSION: The two unique and complementary findings here are that: 1) institutional quality mediates the relationship between ethnicity and hospital discharges AMA; and 2) the relationship between hospital quality and discharges AMA varies with ethnicity.