variables. RESULTS: Of the 2,624 home-testing participants, the overall Hba1c test completion rate was 49.5%, with males significantly more likely to complete the test than females (52.3% vs. 46.1%; c2: p = 0.0011). Although home-testing participation increased significantly with age (c2: p < 0.0001), a significantly lower rate of participation was observed at the highest level of disease severity (c2: p = 0.0006). No significant relationship between participation and income level existed. There was a significant interaction effect between age and gender, with the relationship between gender and home-testing participation reversing as age increased (CMH: p < 0.0001). Gender also significantly mediated the impact of disease severity on participation (CMH: p = 0.001), with the impact of increased disease severity occurring only for females (c2: p < 0.0001). CONCLUSIONS: This study suggests that significant differences in program responsiveness exist by demographic and condition-specific variables. Strategies to effectively target these segments of lower responsiveness will improve the viability and success of a home-based A1c monitoring program.

**PDDB5**

**SELF-MONITORING OF BLOOD GLUCOSE AMONG VETERANS WITH DIABETES MANAGED ON ORAL THERAPY**

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**OBJECTIVE:** The value of self-monitoring of blood glucose (SMBG) by patients with type 2 diabetes is controversial. The objective of this study is to examine the relationship between SMBG and glycemic control among veterans who receive oral hypoglycemic medications only for diabetes. METHODS: Veterans with diabetes mellitus at a Texas Veterans Health Care System were selected by identifying those with an ICD-9 code for diabetes from the outpatient file. Veterans who received continuous care at the VA from FY 2000 to 2002 were selected. From this cohort, a sub cohort of veterans was identified who received oral hypoglycemic medications only during all 3 years of study period. The cohort was placed into 4 mutually exclusive groups based on the duration of SMBG. These groups were defined as “did not receive monitoring strips at all”; “received last year”; “received last 2 years”; and “received all 3 years”. RESULTS: Of the 1185 veterans who received oral hypoglycemic medications, 976 veterans met the criteria for one of the groups. There were no significant differences among the groups on baseline Hba1c, BMI, casemix score. There were significant differences in age and race. Pairwise comparison showed that mean rank for age was older among those who did not receive strips at all compared to those who received strips the last year (p < 0.0083). Results of robust regression showed that age and being Hispanic (compared to white) were significant predictors of Hba1c at FY 2002 (controlling for baseline Hba1c). (F = 49.77 (9, 906 p < 0.001). Age was inversely related to Hba1c. Duration of monitoring (including not monitoring at all) was not a significant predictor of Hba1c at FY 2002. CONCLUSIONS: The results suggest there were some significant differences in age and race among those who received monitoring supplies and those who did not. Receiving strips and duration of receiving strips were not significantly associated with glycemic control.

**PDDB6**

**GENDER DISPARITY IN THE MANAGEMENT OF DYSLIPIDEMIA AMONG TYPE 2 DIABETES PATIENTS IN A MANAGED-CARE SETTING**

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**OBJECTIVES:** Previous research has found that women with diabetes are at a higher risk for cardiovascular disease mortality than men with diabetes. The purpose of this study was to determine whether there were gender-related differences in the management of dyslipidemia in managed care enrollees with diabetes. METHODS: Retrospective cross-sectional analyses were conducted using medical and pharmacy claims data from a large health maintenance organization across a two-year period (2000-1). Patients with type-2 diabetes were identified through a validated algorithm of medication and diagnosis codes. Bivariate analyses were conducted with chi-square analysis to determine if women were less likely than men to receive a lipid test or a lipid-modifying drug. Logistic regression models were also constructed to compare gender-related differences while controlling for age and illness severity. Prior hospitalization and the intensity of diabetes drug therapy served as proxies for illness severity. All statistical analyses were performed using SPSS, version 11.0. RESULTS: A total of 2360 patients with type-2 diabetes were included in the analyses. Across 2000 and 2001, 79.4% of women received a lipid test as compared to 84.2% of men (chi-square = 6.69, p = 0.01). Also, 33.2% of women received a lipid-modifying drug as compared to 45.5% of men (chi-square = 27.31, p < 0.001). Logistic regression analyses revealed that men were more likely than women to receive a lipid test when controlling for age, hospitalization in year 2000, and intensity of diabetes drug therapy (OR = 1.42, CI = 1.09 to 1.84). Men were also more likely than women to receive a lipid-modifying drug when controlling for age, prior hospitalization, diabetes drug intensity and lipid-testing (OR = 1.57, CI = 1.28 to 1.94). CONCLUSIONS: Women with type-2 diabetes were less likely than men with type-2 diabetes to receive lipid tests or lipid-modifying drugs.

**PDDB7**

**ALTERNATIVE ANTIPSYCHOTIC TREATMENT AND RISK OF DIABETES: RESULTS FROM NC MEDICAID POPULATION**

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**OBJECTIVES:** To compare the risk of diabetes associated with olanzapine, quetiapine, and risperidone in treating patients with schizophrenia. METHODS: Schizophrenia patients taking mono-atypical therapy were selected from North Carolina Medicaid Claims database from July 1998 through October 2000. Patients were included if they were continuously eligible in the North Carolina Medicaid program with no diagnosis of diabetes during the three-month pre-treatment period. While controlling for patient demographic and clinical characteristics, comorbidities, and medication use in the baseline period, multivariate logit models were employed to compare the odds ratios for diabetes associated with atypical antipsychotic treatments. RESULTS: A total of 581 patients were included. Of these, 322 initiated olanzapine, 44 initiated quetiapine, and 215 initiated risperidone. Mean age was 40.7 years, 34.7% were men and 46% were whites. No statistically significant differences were found in rates of diabetes among the three cohorts, where the adjusted odds ratio and 95% confidence intervals were 1.39 (0.684–2.838) for olanzapine vs. risperidone, 0.897 (0.255–3.155) for olanzapine vs. quetiapine, and 0.973 (0.495–1.914) for quetiapine vs. risperidone. Otherwise, all included factors being equal, a higher risk of diabetes appeared to be associated with female and the prior use of antidepressants. CONCLUSIONS: Based on the NC Medicaid population, the risk of diabetes for patients with schizophrenia did not appear to differ across the treatment groups of olanzapine, quetiapine, and risperidone.