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Title

Blood pressure control among older community-based African Americans and Latinos with diabetes mellitus.

Permalink

<https://escholarship.org/uc/item/14z7q30p>

Journal

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY, 55(4)

ISSN

0002-8614

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Publication Date

2007-04-01

Peer reviewed

B85

Physician Use of Brand vs. Generic Drug Names in the United States from 1993 to 2004.

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Supported By: San Francisco VA Medical Center, University of California, San Francisco, NIA / AFAR & Lillian R. Gleitsman Summer Training Institute at UCLA, UCSF, and UCHSC, Harvard Medical School

OBJECTIVE: Physician use of brand name terminology for drugs can result in drugs being dispensed in brand form when generic alternatives are available, resulting in billions of dollars of potentially unnecessary spending per year. We used a nationally representative dataset to evaluate how often physicians use brand vs. non-proprietary (i.e., generic) names for drugs, and how use of brand names changes over time.

METHOD: Serial cross-sectional study using data on the 25 most-commonly prescribed drugs from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey in 1993-94 and 2003-04.

RESULTS: In 1993/94, the 25 commonly-prescribed drugs were referred to by their brand names a median of 89% of the time. From 1993/94 to 2003/04, the median decline in use of brand name for these drugs was 11%. Drugs that first had generic competition more than 10 years before or after the baseline study year had smaller declines in brand name use compared to drugs that first had generic competition within 10 years before or after the baseline study year (2-3% decline vs. 43-58% decline, P = .02). In 1993/94, generalist physicians referred to drugs by their brand names more often than specialists (P = .02), yet over the following decade had steeper reductions in use of brand names (P=.03). Year of drug introduction, baseline rate of brand name use, clinical setting, and national region were not associated with reduction in brand name use over time.

CONCLUSIONS: Brand name terminology is commonly used for drugs and decreases over time with the introduction of generic competition. Predictors of the use of brand name terminology can serve as potential guides for interventions to increase the use of non-proprietary terminology.

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Blood Pressure Control among Older Community-Based African Americans and Latinos with Diabetes Mellitus.

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Supported By: Medical Student Training in Aging Research and NIA

Objectives: To assess blood pressure control among older African Americans and Latinos with poorly controlled diabetes mellitus (DM) and to determine demographic, clinical, and psychosocial correlates of BP control

Design: Secondary analyses of a descriptive cohort study at baseline and 6 month follow-up

Setting: Senior centers, churches, and community clinics in the LA County area

Participants: Total of 333 participants who: 1) had a hemoglobin A_{1c} level > 8%, 2) were aged 55 and older, and 3) were either African American or Spanish-speaking Latinos

Intervention: Self Care was a randomized controlled behavioral intervention to enhance DM self-management. **Measurements:** BP control; **Demographic:** age, sex, ethnicity, education, income, insurance status, mean monthly medication costs; **Clinical:** body mass

index, duration of diabetes, comorbidity score, Hb A_{1c} percentage, number of hypertension medications, low density lipoprotein cholesterol; **Psychosocial:** DM-specific self-efficacy, self-efficacy in communication with physician, medication adherence, general social support, DM-specific social support

Results: At baseline, the correlates of inadequate blood pressure control were: an increased number of hypertension medications (p=0.007) and older age(p=0.04). At 6 month follow-up, the correlates of inadequate control were: lower self-efficacy for communication with physician measured at baseline(p=0.002) and being African American(p=0.03).

Conclusion: Findings suggest that improving communication with providers may be one mechanism for improving BP control.

Key words: Blood pressure control, older African Americans, older Latinos, poorly controlled diabetes

Significant Multivariate Correlates of BP Control (SBP > 140 vs. < 140)

	BASELINE *	6-MONTHS **
	OR (P)	OR (P)
No. of HTN Medications	1.35 (0.007)	1.25 (0.06)
Self-Efficacy for Communication with Physician	0.9 (0.13)	0.78 (0.002)
Age (per year)	1.05 (0.04)	1.02 (0.40)
African American	1.006 (0.99)	0.41 (0.03)

* Also adjusted for sex, education, comorbid conditions, insulin use, insurance status, medical adherence, social support, and DM-specific social support

** Also adjusted for study arm

B87

Vitamin D Screening Study Changes Physician Practices and Patient Attitudes.

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Supported By: Hartford Center of Excellence in Geriatric Medicine Henry Adelman Fund for Medical Student Education

Purpose: A recent study found a surprisingly high prevalence (60%) of low 25-hydroxyvitamin D [25(OH)D] levels among older adults (>65 years) enrolled in a university-affiliated geriatric care practice. Given these unexpected results, the current study 1) surveyed providers as to their attitudes/experiences regarding vitamin D screening, 2) assessed for overall practice changes in 25-(OH)D assay ordering, and 3) surveyed patients from the prevalence study to evaluate their attitudes/experiences about being screened.

Methods: Interviews were audiotaped with all 14 physicians and nurse practitioners providing care at the New York City practice to assess their attitudes about and perceived barriers to vitamin D screening. The total number of 25-(OH)D assays ordered in the practice before and after the prevalence study was also quantified. A subset of patients was surveyed by phone to evaluate their experiences. Target sample size was 100 patients (50 sufficient, 50 insufficient D levels).

Results: Most providers (93%) provisionally supported universal screening for vitamin D, with 50% voicing a desire to retain the ability to individualize treatment. Also, 43% cited the need for more evidence showing the benefits of D repletion. Barriers to screening included a lack of provider knowledge of vitamin D metabolism or repletion regimens (79%), cost concerns (36%), and competing priorities (29%). When compared to the average number of vitamin D assays ordered during the 8-month period before the study (4.8/month), a 7-fold increase in testing was observed in