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Use of vision services and satisfaction with care among medicare beneficiaries with fee-for-service versus managed Medicare.

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CG group had more 'strongly agree' scores of negative impacts of MC versus PQE residents (p < 0.01) in following 4 areas: Restrict Referrals, Threaten Patient Relationship (p < 0.05), Causes Poorer Outcomes for Sicker Patients, and Omission of Beneficial Tests.

CONCLUSION: This program was funded by Partnerships for Quality Education (PQE), an $8.3 million collaborative grant initiative from Pew Charitable Trusts and Commonwealth Fund. Such an innovative program with academic health centers, managed care organizations and funding agencies learning together can be a major instrument of change.

USE OF VISION SERVICES AND SATISFACTION WITH CARE AMONG MEDICARE BENEFICIARIES WITH FEE-FOR-SERVICE VERSUS MANAGED MEDICARE.
CM Mangione, EB Keeler, JL Adams, PP Lee, AL Coleman, MF Shapiro, Dept. of Medicine, UCLA School of Medicine, Los Angeles; Health Program, RAND, Santa Monica, CA

PURPOSE: To determine whether there are differences in use of vision services, quality of vision care, and overall satisfaction with care among Medicare patients in fee-for-service (FFS) versus managed care (MC).
METHODS: Cross-sectional survey of 1061 randomly sampled MC patients from 27 physician groups who contract with one large for-profit HMO in Los Angeles and 236 FFS patients matched to the MC sample by zip code, comparing use of vision services, visual disability, presence of chronic eye and medical problems, SF-12 health status, satisfaction as measured by the CAHPS 1.0, and demographic characteristics. Multivariate analyses compare rates of annual dilated eye exams and cataract surgery, selected CAHPS scales, and severity of visual disability by FFS versus MC. Also survey of physician groups (response rate 96%) to determine whether features of MC physician groups influence rates of dilated eye exams and cataract surgery, selected CAHPS scales and visual disability. Domains measured included: linkage of PCP compensation to specialty referral volume; capitation experience; and availability of specialty care within the group. All regression analyses were adjusted for independent effects of age, gender, income, race, Medicaid, health status, medical and eye conditions.
RESULTS: Response rate was 65%. Demographics were mean age of 75 years, 59% female, 18% Latino, 17% African American, and 7% Medicaid. All demographic characteristics were similar for FFS versus MC except for Latino ethnicity (20% in MC sample vs 10% in FFS, p = .001). Prevalence of medical and eye diseases and mean SF-12 scores did not vary by FFS versus MC. Multivariate analyses indicate that FFS patients were more likely to have had dilated eye exams during the past year at 55% vs 48% for MC (p = .05), had similar rates of cataract surgery at 11% vs 12% for MC, and reported less visual disability (p = .01). Those in FFS rated quality of eye care and health care overall significantly higher than persons in MC (p < .05). CAHPS rating of getting needed referral care was high and similar in both settings. Persons cared for in groups where PCP compensation was linked to referral volume had a trend toward fewer dilated eye exams (p = .06), and toward reporting more trouble getting needed care (p = .07). Patients cared for in groups less experienced with capitation had higher rates of cataract surgery (p = .03).
CONCLUSION: Persons in FFS had significantly more eye exams, better visual functioning, and better satisfaction with care when compared to those with managed Medicare. Linkage of PCP compensation to volume of referral care within managed care may lead to less specialty service use and lower perceived access to care.

VARIATION BY REGION IN THE FINANCIAL AND ORGANIZATIONAL STRUCTURE OF PHYSICIAN GROUPS IN CALIFORNIA AND THE PACIFIC NORTHWEST.
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PURPOSE: To describe variation in the financial and organizational structure (FOS) of physician groups by region.
METHODS: Developed and administered a 45 minute telephone survey to measure structure in the following areas: 1) immutable characteristics of provider groups such as size and profit status; 2) compensation arrangements for physicians; and 3) the process of monitoring referral care and resource use.
RESULTS: Medical Directors from 54 of 57 physician groups who are participants in the 1998 Physician Value Check Survey project completed the FOS (96% response rate). These physician groups which provide the majority of managed care in these markets are geographically dispersed with 48% in Southern California, 39% in Northern California, and 13% in the Pacific Northwest. The percent of revenue derived from capitated contracts, where groups are compensated at a fixed amount per member per month, was highest in Northern California at a mean +/− SD of 86 +/− 24% and lowest in the Pacific Northwest at 33 +/− 14% (p = .0001). The dominant form of primary care physician (PCP) compensation also varied by region:

	Pac NW (%)	N. Cal (%)	S. Cal (%)	p
Salary	0	29	42	.001
FFS	100	19	15	
Capitation	0	48	38	
Mixed mode	0%	4%	5%	
Bonus/Withold	29	62	46	.85

With full risk contracting, physician groups are motivated to monitor the appropriateness and volume of referral care. The most frequent management strategies used in all regions at similar proportions include: mandatory pre-authorization from the group for specialist visits (43%) or procedures (76%); pre-authorization by the PCP for specialist visits (72%); PCP-level profiling with feedback (74%); and implementation of formal guidelines that provide criteria with regard to appropriate use of referral care (74%).
CONCLUSION: Financial and organizational structure varies widely for the groups which provide the majority of care to the managed care populations in these regions. Linkage of these structural characteristics to patient level data will be critical to determine whether physician group characteristics are associated with better outcomes of care.

WHICH PRIMARY CARE PATIENTS WITH ALCOHOL DISORDERS RECEIVE TREATMENT?
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PURPOSE: Little is known about possible differences between primary care patients who have and have not been treated for alcohol disorders. We examined the health status and clinical characteristics of ambulatory patients with alcohol disorders (AD) who had and had not received treatment.
METHODS: Cross-sectional sample and survey of 6829 males who use VA ambulatory services in the greater Boston area. Patients were defined as having AD if CAGE was greater than or equal to 2 and current (CAD) if they had had a drink in past year, else abstinent (AAD). According to self-report of treatment, patients were further classified as treated (CADT or AADT) or never treated (CADNT or AADNT); patients with a CAGE = 0 and no history of treatment were classified as NOAD. The total number of physical (PHYS) and psychiatric (PSYCH) comorbidities was based on a medical history interview. Health status was measured with the SF-36 from the Medical Outcomes Study using two summary scores, PCS (physical component summary scale) and MCS (mental component summary scale). Higher scores denote better function. Patients with current AD completed the alcohol section of the QDIS, a diagnostic interview for DSM-III-R. ANCOVA adjusted for age was used to compare PHYS, PSYCH, PCS, and MCS scores. Tukey's test was used for multiple between group comparisons; all p values are <0.05 two-tailed.
Results: 2425 of 4236 (57%) eligible patients completed the survey.

	CADNT	CADT	AADNT	AADT	NOAD
N	170	141	69	124	1458
Age	56.4[a]	55.5[a]	63.3	58.0[a]	63.9
Married	45.5[a]	39.7[a]	60.3	41.5[a]	64.5
PHYS	5.1	6.4[a]	5.2	5.6	4.9
PSYCH	0.8	1.5[a]	0.9	1.4[a]	0.6
PCS	38.7[b]	33.4[a]	35.2	37.2	37.0[b]
MCS	45.7[a,b]	39.7[a]	47.6[b]	44.1[a]	49.8[b]

[a]differs from NOAD, [b]differs from CADT

CONCLUSION: Patients who achieved abstinence without treatment (more than 10% of all those with AD) have health and health status comparable to those without alcohol disorders. Our results suggest that patients with the greatest burden of illness are those who receive treatment and that abstinence improves mental health status.

CAUSES OF ANTIBIOTIC RESISTANCE: ATTITUDES AND PERCEPTIONS OF RESIDENTS COMPARED TO ATTENDINGS.
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PURPOSE: Antibiotic resistance is a growing health problem. Little is known about the attitudes and perceptions of physicians regarding its causes, and no study has ever been published comparing internal medicine residents to attendings. It is perceived that residents don't have an adequate appreciation of antibiotic usage and its ramifications.
METHODS: A survey containing a 19 item self-administered questionnaire was sent to 488 internal medicine physicians in 4 Chicago hospitals, of which 424 (87%) were returned completed. The survey asked physicians to rank potential causes of antibiotic resistance, ranging from "unimportant" to "extremely important." The sample included 243 internal medicine residents and 181 internal medicine attendings. The residents included 143 from a public hospital and 100 from a university hospital, and the attendings included 114 general internists, 21 ID specialists, and 46 other specialists.
RESULTS: Resident physicians consistently ranked all the potential causes of antibiotic resistance as high or higher (in terms of potential importance in causing the problem) than attending physicians. Specifically, residents ranked 6 potential causes at a statistically significant higher level compared to attendings. These included: 1. Prescribing antibiotics for self-limited bacterial infections. 2. Prescribing antibiotics for self-limited non-bacterial infections. 3. Prescribing antibiotics for shorter than recommended duration. 4. Prescribing antibiotics empirically without a definite diagnosis of bacterial infection. 5. Prescribing broad spectrum antibiotics when equally effective narrower spectrum antibiotics are available. 6. Having poor access to good information on local antibiotic resistance patterns. There were 12 potential causes ranked at similar levels by residents and attendings. Only one cause was ranked at a statistically significant lower level by resi-