VARIATION BY REGION IN THE FINANCIAL AND ORGANIZATIONAL STRUCTURE OF CARE AMONG MEDICARE BENEFICIARIES WITH FEES-FOR-SERVICE VERSUS MANAGED MEDICARE.

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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 except managed care capitation; and availability of specialty care within the group. All regressions analyses were adjusted for independent effects of age, gender, income, race, Medicare, 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 = .005), had similar rates of cataract surgery at 11% vs 12% for MC, and reported less visual disability (p = .01). Those in FFS reported better quality of eye care and health care overall significantly higher than persons in MC (p < .05). CAHPS ratings 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 of physician groups by region.

METHODS: Developed and administered a 45 minute telephone survey to measure structure in the following areas: 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 care to the managed care populations in these regions included: linkage of PCP compensation to volume of referral care within the group for specialist visits (43%) or procedures (76%); pre-authorization by the PCP for specialist visits (72%); FCP-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 (CADT). According to self-report of 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) comorbidity 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 QODS, a diagnostic interview for DSM-III R. AADNT was judged 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 <.05 two-tailed.

RESULTS: 2425 of 4236 (57%) eligible patients completed the survey.

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 448 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 medical 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 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. Concern over access to good health 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-