Title
Barriers to providers considering medication costs to patients when prescribing

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CONCLUSIONS: Numerous subject, healthcare provider, policy and test specific barriers to and facilitators of CRC screening in the elderly were identified. They might be used to better tailor interventions to increase CRC screening participation rates in the elderly.

BARRIERS TO PROVIDERS CONSIDERING MEDICATION COSTS TO PATIENTS WHEN PRESCRIBING C. Tseng[1]; C.M. Mangione[2]; E. Keeler[3]; A. Hixon[4]; D. Lee[5]; E. Jackson[6]; R.A. Dudley[7]. [1]University of Hawaii Dept of Family Medicine and the Pacific Health Research Institute, Honolulu, HI; [2]University of California, Los Angeles, Los Angeles, WY; [3]RAND, Santa Monica, CA; [4]University of Hawaii JABSOM Dept. of Family Medicine and Community Health, Honolulu, HI; [5]University of Hawaii Dept of Family Medicine and Community Health, Honolulu, HI; [6]U Connecticut School of Medicine, Farmington, CT; [7]University of California, San Francisco, San Francisco, CA. *(Tracking ID # 189814)*

BACKGROUND: Many patients turn to providers to ask for help with drug costs, yet anecdotally, providers say they often do not know how much patients pay for medications. We examined 1) providers' reports of whether they know patients' cost-sharing for medications at the time of prescribing, 2) providers' descriptions of barriers to knowing costs, and 3) whether use of information technology (e.g., electronic prescribing) in clinical practice is associated with better provider knowledge of medication costs.
METHODS: We conducted a 2007 cross-sectional survey of all community providers of out-patient adult primary care in Hawaii (general internists, family practitioners, general practitioners, physician assistants, nurse practitioners. Providers were eligible if they reported seeing more than 20 patients per week. Kaiser, military, and academic teaching clinics were excluded. Main outcomes included providers' self-report of how often they knew medication copays and retail prices at the time of prescribing, barriers to obtaining this knowledge, and any regular use of four types of information technology in clinical care (internet, PDA, electronic prescribing, electronic health records). Multivariate logistic regression was used to determine if any of the information technologies were associated with better self-reported knowledge of medication costs after controlling for provider and practice characteristics.
RESULTS: A total of 262 providers completed surveys and were eligible (60% response rate). Participants were on average 50 years old, 65% were male, two-thirds were in private practice, and 41% were solo practitioners. Nearly all (98%) said it was important to consider medication costs for their patients. Many providers reported regularly using the internet (61%), electronic prescribing (53%), electronic health records (42%), or PDAs (39%) in clinical practice. The great majority of participants said they rarely or only sometimes knew drug copays (82%) and retail prices (81%) and that it was difficult to know how much a drug would cost their patients (83%). The main barriers to considering medication costs for patients were not knowing formularies (95%) and copays (92%), and lack of time (82%). Use of any of the four information technologies measured was not associated with more frequent knowledge of copays or retail prices or with greater ease in knowing coverage. Providers who faced a higher number of formularies in practice (6 or more vs. 5 or less formularies) were more likely to report difficulty knowing whether a drug was covered for their patients. (OR 2.0 95% CI 1.1 – 3.7).
CONCLUSIONS: The great majority of providers encountered difficulty knowing how much prescriptions would cost their patients, even with the use of information technology in clinical care. These findings demonstrate the that there is still a need to improve providers' access to medication costs and their ability to use such cost information from numerous plans in a practical way at the point of prescribing.

BE FIT WORKSITE WELLNESS PROGRAM TO PROMOTE WEIGHT LOSS AND PHYSICAL ACTIVITY A.N. Thorndike[1]; E. Healey[2]; L. Sonnenberg[2]; K. Brill-Daley[2]; S. Regan[2]. [1]Massachusettes General Hospital and Harvard Medical School, Boston, MA; [2]Massachusetts General Hospital, Boston, MA. *(Tracking ID # 190122)*

BACKGROUND: The prevalence of obesity and poor fitness continues to rise despite being a public health priority. A worksite provides the opportunity to address obesity and sedentary lifestyle in a large population. We conducted a voluntary 12 week intensive lifestyle modification program (Be Fit) to promote weight loss and physical fitness for employees at Massachusetts General Hospital.
METHODS: All full-time employees were eligible to participate. Employees formed teams of 25 members from hospital departments; 6 teams participated every 12 weeks. The program was offered during work hours and at no cost to employees. Each team met once a week with a nutritionist and a trainer, and all participants were given a free gym membership and the option of working individually with a personal trainer and a nutritionist. Teams competed on a weekly basis for weight loss, duration of exercise, and number of food records completed. Each participant completed a physical assessment and a survey at baseline and at 12 weeks. We analyzed change in behavioral (eating patterns and exercise hours), physical (weight, blood pressure, heart rate), and serological (cholesterol, glucose, and C-reactive protein) outcomes from baseline to the end of the program. We used multivariate linear regression to assess the effects of age, sex, and change in activity level, fruit and vegetable intake, and fat consumption on the percent of body weight lost during the program.
RESULTS: From December 2006 through September 2007, we enrolled 586 subjects; 91% were female, and the mean age was 42. At baseline, 65% of subjects were overweight or obese (BMI>25) and 59% spent less than 2 hours per week doing recreational physical activity. At the end of the program (12 weeks), 41% (95% CI: 37–45%) of subjects increased their physical activity levels by more than 2 hours per week. Fruit and vegetable intake increased in 37% (95% CI: 32–42%) of subjects, and fat intake decreased in 33% (95% CI: 28–38%). Changes from baseline to 12 weeks in physical and serum measurements are shown in the table. In a multivariate analysis, older age (p=.001), increase in physical activity (p<.001), and decrease in fat consumption (p=.02) were significant predictors of weight loss during the program.
CONCLUSIONS: A voluntary worksite lifestyle modification program resulted in significant decrease in weight and cardiovascular risk factors of employees at a large hospital. Weight loss at the end of the program was associated with increased physical activity and decreased consumption of fats. Future research should focus on worksite interventions to maintain these changes in order to prevent chronic diseases associated with obesity and sedentary lifestyle.

Changes in measurements from baseline to 12 weeks

Measure	Baseline	Week 12	Change	P
Mean weight (lbs)	175.1	168.6	−6.4	<.001
Mean systolic BP (mm Hg)	125	121	−4	<.001
Mean diastolic BP (mm Hg)	74	72	−2	<.001
Mean waist (inches)	34.5	32.5	−2.0	<.001
Mean total cholesterol (mg/dL)	192	183	−9	<.001
Mean LDL cholesterol (mg/dL)	108	103	−5	<.001
Median glucose (mg/dL)	90	91	1	NS
Mean C-reactive protein (mg/L)	3.3	3.1	−0.2	NS

BEING THERE WHEN NOBODY ELSE IS THERE: SOCIAL ISOLATION, CHRONIC ILLNESS AND THE IMPACT OF CASE MANAGEMENT E. Davis[1]; A. Fernandez[1]; A. Tamayo[2]; M.E. Schneidermann[1]. [1]University of California, San Francisco, San Francisco, CA; [2]University of Washington, San Francisco, CA. *(Tracking ID # 190934)*

BACKGROUND: Case management programs for people with a history of homelessness and frequent hospitalizations use an array of medical and social interventions to increase access to housing and medical care. These programs are usually designed without input from target populations. Often, what participants in these programs value and believe helpful in improving health is not known. This study was done to explore the perceptions of marginally housed, chronically ill patients who participated in a case management program previously shown to improve health outcomes.
METHODS: This qualitative study used in-depth, face-to-face interviews with participants in a social work based, assertive case management program for patients who had three or more admissions per year to a public hospital. The interdisciplinary program had a social worker to patient ratio of 1:15. Enrollment in the study was stopped when thematic saturation was achieved, which occurred after interviews with 14 participants. The interview guide probed experiences with the