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UNFAVORABLE OUTCOMES IN HYPERTENSIVE MEDICAID RECIPIENTS RAISE OPPORTUNITIES FOR PROFESSIONAL EDUCATION
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Background: Residence in the Southeast U.S., minority status, and low income are additional risk factors for cardiovascular and renal disease. Hypertensive Medicaid beneficiaries in South Carolina are disproportionately minority, and by definition, low income and living in the Southeast.

Methods: To further characterize health outcomes in this high-risk population, data obtained from billing records on hospitalization and prescription medication use after discharge were examined in collaboration with Carolina Medical Review on the 26,591 continuously enrolled hypertensive beneficiaries in the South Carolina Medicaid program during 1998-9.

Results: The combined hospital admission rates for just 5 diagnoses exceed 200/1000 patients over 2 years, i.e., >10%/year. For example, the hospitalization rate/1000 beneficiaries during 1998-9 was 73 for congestive heart failure, 68 for diabetes mellitus, 40 for stroke (31 non-hemorrhagic, 9 hemorrhagic), and 35 for acute myocardial infarction. Among patients admitted with congestive heart failure, 33% filled a prescription for an angiotensin converting enzyme inhibitor within 90 days of hospital discharge. Similarly, 13% of Medicaid hypertensive patients admitted with an acute myocardial infarction obtained a beta-blocker within 90 days of hospital discharge.

Summary: The data confirm the impression that hypertensive Medicaid patients are at high risk for major morbidity leading to hospital admissions. Moreover, many of the hypertensive patients have diabetes as a comorbidity (35%), which leads to frequent hospitalization. The data also indicate a high rate of hospital readmission (not shown). The high admission and readmission rates are associated with suboptimal use of evidence-based medications that have been proven to improve health outcomes and reduce hospital admissions. The failure of Medicaid patients to obtain evidence-based treatment probably does not reflect a policy limitation, since prescriptions for hypertensive Medicaid beneficiaries are not restricted.

Conclusion: Professional education aimed at increasing the efficacy of the patient-provider interaction, e.g., ensuring proper prescribing behavior and implementing strategies for enhancing patient adherence, could have favorable health and economic implications for the Medicaid system and its beneficiaries. Improved outcomes for Medicaid beneficiaries would also reduce racial disparities in hypertension-related complications.

Key Words: Medicaid Beneficiaries, Hypertension, Hospitalization and Medications

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BLOOD PRESSURE CONTROL IN PATIENTS WITH DIABETES MELLITUS AT DIFFERENT INSTITUTIONS
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To determine the percentage of patients with diabetes and hypertension who met the American Diabetes Association (ADA) treatment guidelines of a BP 130/80 mmHg.

In a cross sectional study, using the 2001 ADA guidelines, we evaluated BP control in 1039 clinic patients with diabetes and Hypertension, followed at 3 different outpatient practice settings in New York City, 2 Municipal Hospitals (Kings County and Woodhull) (KCH/WH), a Veteran Administration Medical Center (Brooklyn) (VAMC), and University Hospital affiliated office- based practices, (Staten Island) (SIUH).

Of the total of 1039 patients, 32.1% received care at VAMC, 48% at KCH/WH and 15% at SIUH. The mean age 60.8 ± 0.4 years (± SE), (range = 13-95), 44.8% were women, 93% had type 2 diabetes and the mean BMI was 29.5 Kg/m². The mean treated systolic and diastolic BP were 141.5 ±0.7 and 77.5 ±0.4 mmHg respectively. A BP goal of <130/80 mmHg, was achieved in 28.2% of the entire cohort, in 40.9% of patients followed at VAMC, 16.9% of those followed at KCH/WH and 40.3% of those followed at SIUH.

Although differences exist between institutions, optimal BP control in patients with diabetes was achieved only in a minority of patients, reflecting that the ADA guidelines has not been fully translated into clinical practice.

Key Words: Diabetes Mellitus, Hypertension, Guidelines

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IMPROVED BLOOD PRESSURE CONTROL USING A PHYSICIAN-SUPERVISED NURSE-MANAGED CLINIC (MDRNC) AND HOME BLOOD PRESSURE MEASUREMENT

Less than 30% of hypertensive patients in the United States have blood pressures controlled to <140/90 mm Hg. New management paradigms are clearly needed to address this challenging issue. Due to a geographically disperse referral population, an MDRNC was developed to evaluate hypertensive patients, initiate or adjust antihypertensive drug therapy, and provide educational counseling. Patients with systolic BP (SBP) ≥140 and/or diastolic BP (DBP) ≥90 mmHg were enrolled in this prospective study. Participants were provided accurate fully automated BP monitors and requested to submit by mail 42 BP readings taken over 7 days at 1, 3, 6, 9, and 12 months after dismissal from the clinic. These data were reviewed by the MD/RN team and drugs were adjusted (according to JNC 6 guidelines) by phone or mail if the average BP was ≥135/85 mmHg. 106 pts were enrolled (mean age 64y, 58% female). BP data as mean ± SE, mm Hg:

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>1m</th>
<th>3m</th>
<th>6m</th>
<th>9m</th>
<th>12m</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>106</td>
<td>100</td>
<td>88</td>
<td>71</td>
<td>77</td>
<td>73</td>
</tr>
<tr>
<td>SBP</td>
<td>156 ±2</td>
<td>138 ±2</td>
<td>135 ±2</td>
<td>133 ±2</td>
<td>131 ±1</td>
<td>131 ±1</td>
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<tr>
<td>DBP</td>
<td>85 ±1</td>
<td>78 ±1</td>
<td>77 ±1</td>
<td>75 ±1</td>
<td>75 ±1</td>
<td>75 ±1</td>
</tr>
<tr>
<td>%&lt;135/85</td>
<td>0</td>
<td>41</td>
<td>48</td>
<td>54</td>
<td>56</td>
<td>62</td>
</tr>
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</table>

Intensification of the drug regimen to achieve goal BP was necessary, on average, in 29% of patients at each interval based on home BP data. In the 73 patients completing the study, BP decreased from 154±2/84±1 mm Hg at baseline to 131±17/51±1 mm Hg at 12 months (p<.01). There