Research

Telephone-Based Cognitive Behavioral Therapy for Insomnia

In this study, McCurry and colleagues compared the treatment efficacy of telephone-based cognitive behavioral therapy for insomnia (CBT-I) with menopause education control (MEC) to improve sleep in 106 perimenopausal or postmenopausal women aged 40 to 65 years reporting moderate-to-severe insomnia symptoms and 2 or more daily hot flashes. The cohort was randomized and assessments were conducted at baseline, 8 weeks (postintervention), and 24 weeks (follow-up). Study results showed that women receiving CBT-I had significantly greater improvements in sleep than women receiving MEC at 8 and 24 weeks on multiple self-reported outcomes. There were no differences between groups in hot flash frequency or severity, but hot flash interference also significantly decreased at 8 and 24 weeks for women who received CBT-I compared with MEC.

Posthospitalization Function and Community Mobility

In this study, Brown and colleagues used a single-blind randomized trial design and found that a mobility program (MP) that included offering assistance with ambulation linked with a behavioral intervention and focused on goal setting and addressing mobility barriers prevented loss of community mobility 1 month after hospital discharge. Those who received usual care (UC) experienced a decline in community mobility. Functional status as measured by activities of daily life was not significantly different between the UC and MP groups either before or after the hospitalization. Because low mobility in the hospital is associated with adverse outcomes, including functional decline and nursing home placement even after controlling for illness severity and comorbid illness, these findings have potentially significant clinical implications.

Cancer Screening Using a Health Information Technology System

In this study, Percac-Lima and colleagues evaluated the effectiveness of patient navigation as a part of a population-based health information technology system to improve preventive cancer screening in patients at high risk for not completing testing. In a large primary care network, patient navigation significantly increased screening rates for breast, cervical, and colorectal cancer. Integrating patient navigation for vulnerable patients into population health management activities could potentially improve equity of cancer care.

Central Assistance for Posttraumatic Stress Disorder

STEPS-UP (Stepped Enhancement of Posttraumatic stress disorder [PTSD] Services Using Primary care), a randomized clinical trial conducted by Engel and colleagues, sought to determine the effectiveness of centrally assisted collaborative telecare (CACT) for PTSD and depression in affected military members attending primary care. Patients in 18 primary care clinics at 6 sites in the United States were randomized to receive 12 months of CACT or usual integrated primary care. Centrally assisted collaborative telecare consisted of central implementation assistance with the provision of nurse care management, remote psychosocial intervention and routine psychiatrist consultation, and production of electronic record based illness patient registries used to adjust treatment in nonimprovers and reengage those lost to clinical follow-up. Patients receiving CACT reported greater decreases in PTSD and depression scores over 12 months of follow-up, and more patients reported clinically significant improvement. Effects were modest compared with usual care but results suggest that central assistance for collaborative care implementation may improve primary care outcomes of PTSD and depression, particularly for military personnel.
Opioid Analgesics for Low Back Pain

Opioid analgesics are widely prescribed for the management of low back pain. In this review of the available evidence, Shaheed and colleagues found that recommended doses of opioid analgesics ranging from 40.0 mg to 240.0 mg morphine equivalents/day did not provide clinically meaningful pain relief (>20 points on a 0-100 point pain scale) in people with low back pain. Given the potential for significant drug-related harms of opioid analgesics, these findings have significant implications for prescribers and policy makers in managing low back pain.

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Type 2 Diabetes, Severe Hypoglycemia, and Intensive Treatment

Using an administrative dataset, McCoy and colleagues identified 31,542 adults in the United States with type 2 diabetes who achieved and maintained hemoglobin A1c (HbA1c) less than 7% without insulin, including 3,910 patients with high clinical complexity owing to advanced age 75 years or older and/or presence of multiple or life-limiting serious comorbidities. Overall, 25% of patients received intensive glucose-lowering treatment, including 21% of patients with high clinical complexity who are unlikely to derive long-term benefit from such intensive HbA1c control. In this vulnerable group, intensive treatment significantly increased the risk-adjusted probability of severe hypoglycemia by 77%, from 1.74% to 3.04% incidence over 2 years. Intensive glucose-lowering treatment among older, clinically complex patients may not be clinically beneficial and is associated with significant harm, particularly severe hypoglycemia.

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Hypertensive Urgency in the Office Setting

Patel and colleagues found that hypertensive urgency accounted for up to 5% of all office visits in a large health care system, but less than 1% were referred to the hospital. Major adverse cardiovascular events were rare and did not differ between patients sent home vs those referred to the hospital. Referral to the hospital was associated with higher rates of all-cause hospital admissions within 30 days. At 6 months, two-thirds of all patients still had uncontrolled blood pressure.

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Low-Value Care in Medicaid

In a study using comprehensive data from Oregon, Charlesworth and colleagues found that moderate proportions of Medicaid and commercially insured patients received care likely to provide relatively little clinical benefit. Among qualifying Medicaid patients, 15% received a low-value service during 2013, compared with 11% of qualifying patients with commercial insurance. Results showed there was no consistent association between insurance type and low-value care across services and did not support a hypothesis that provision of low-value care might be driven by higher reimbursement rates. However, Medicaid and commercial rates of low-value care were associated within service areas, suggesting that provision of low-value care may be related to local practice patterns.