Panel A of the Figure displays the unadjusted survival curves for admitted vs nonadmitted patients. The estimated hazard ratio comparing admitted vs nonadmitted patients from the adjusted Cox model was 1.20 (95% CI, 1.01-1.43). A Cox model with center as a random effect (P=.003) yielded a hazard ratio of 1.16 (95% CI, 0.93-1.45). Panel B of the Figure is a plot of the adjusted survival curves, showing a decrease in survival for patients admitted to the ICU compared with those not admitted (estimated IPW hazard ratio, 1.19; 95% CI, 1.01-1.45).

Comment. In this observational prospective cohort study, we were unable to show any benefit of ICU admission for very old patients. We chose to focus on long-term survival, more relevant than hospital survival, to investigate potential ICU benefit.

This result should be interpreted cautiously because (1) we had no information on therapeutic limitation and (2) patients were not randomized and therefore residual confounding may still be present. Moreover, we cannot draw any conclusion on the benefit of ICU admission for accurately selected very old patients.

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Health Care Reform

Declines in Physician Acceptance of Medicare and Private Coverage

A number of articles in the lay and medical press report a decline in the number of physicians who accept patients with Medicare,1-3 however, to our knowledge, recent trends in acceptance of different types of insurance have not been examined. Using data from a national survey of physicians, we examined trends in physician acceptance of different types of insurance and self-pay patients. Understanding these trends can help inform policy makers of potential access problems, particularly given the shortages in primary care, an aging population, growing prevalence of chronic disease, and insurance expansion under the Patient Protection and Affordable Care Act.4,6
Results. The percentage of physicians accepting new patients did not vary significantly between 2005 and 2008, ranging from 94.2% to 95.3%. Physician acceptance of new Medicare patients dropped from 95.5% in 2005 to 92.9% in 2008 ($P=.01$) (Figure). Physicians in private practice were largely responsible for the declining acceptance of Medicare patients as determined in stratified analyses (95.5% in 2005 vs 93.0% in 2008; $P=.01$) (eTable; http://www.archinternmed.com).

There was a more pronounced decline in physician acceptance of patients with private noncapitated insurance (93.3% in 2005 vs 87.8% in 2008; $P<.001$). A smaller percentage of adult primary care physicians accepted private noncapitated patients over the study period (97.3% in 2005 vs 89.9% in 2008; $P<.001$).

Rates of acceptance of new Medicaid and private capitated patients were lower than Medicare and private noncapitated insurance, but also showed a decline over the study period. Acceptance of self-paying patients was more than 96% in all years and did not change significantly over the study period.

Comment. While reports in the press highlight physicians’ dissatisfaction with Medicare,1,2 we found only a small decline in physician acceptance of Medicare patients between 2005 and 2008. In contrast, the decline in physician acceptance of noncapitated privately insured patients was more pronounced. Physicians continued to accept patients who were self-paying.

Although physician reimbursement under Medicare is often cited as the reason why physicians turn away Medicare patients, our findings suggest that more than 90% of physicians continue to accept Medicare patients despite marginal increases in reimbursement suggest that anecdotal reports may be overstating access problems.8 However, it is possible that practices are accepting Medicare patients in general but are accepting fewer.

The observed decline in acceptance of private noncapitated insurance was unexpected and could be related to reimbursement but also to administrative burden.9 Acceptance rates of capitated insurance was lower and may reflect lower reimbursement in this model. Finally, the low and declining acceptance of new Medicaid patients is not surprising given the program’s historically poor reimbursement rate.10 Low rates of Medicaid acceptance may threaten access to care for the estimated 16 million Americans who will receive Medicaid coverage as a result of the Patient Protection and Affordable Care Act.6

Our study was limited by our inability to assess acceptance of insurance by physicians practicing in hospital outpatient departments. Nonetheless, our findings suggest that access to care is becoming increasingly restricted for certain types of insurance. Understanding the underlying reasons for the decreased acceptance of insurance could help direct changes in policy and are imperative in light of impending expansion of health insurance coverage in the United States.

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Prediction of Risk of Falling, Physical Disability, and Frailty by Rate of Decline in Grip Strength: The Women’s Health and Aging Study

Aging people progressively lose skeletal muscle mass and strength.1 Epidemiologically, a single measurement of grip strength has repeatedly proven to correlate with subsequent adverse health outcomes2 even when measured in midlife to predict physical disability decades later.3 This has led some to propose that grip strength be used clinically as an indicator of risk for decline in health, or even as a new “vital sign.”2,4 However, it remains unclear whether the risk of developing adverse outcomes is greater or less for a person who is relatively weak compared with other age-matched individuals than it is for a relatively strong person whose strength is declining rapidly. We hypothesized that those with a faster rate of decline would be at higher risk compared with those who had a weaker single grip measurement. We tested this hypothesis using longitudinal data from older women studied for the evolution of disability and functional decline with aging.

Methods. The Women’s Health and Aging Study (WHAS) II is an institutional review board–approved, prospective cohort study of 436 women aged 70 to 79 years with high functional ability at baseline, as previously described.5 Data were collected at baseline and 6 follow-up examinations approximately 18 months apart, except for the interval between the third and fourth examination, which was on average 3 years, resulting in a median follow-up time of 9 years (ranging from 1.5 to 13.3 years) between 1994 and 2008. The analytic sample for this report consisted of 352 women who had baseline data available on all covariates and had at least 2 measurements on grip strength during the follow-up period.

Grip strength was measured using a JAMAR hand dynamometer (Model #BK-7498; Fred Sammons Inc, Burr Ridge, Illinois).2 The maximum measurement of 3 trials in the nondominant hand was used in the analyses.6 Outcomes of the study included incident health events: falls, walking speed slower than 0.4 m/s, the WHAS frailty phenoty,7 and difficulty in 1 or more task (“disability”) of the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scales.8

We used a linear random effects model (REM) to assess population average rate of change in grip strength over time (ie, fixed effects) by including age in the model as a time-dependent covariate. To account for the observed nonlinear time trend in change of grip strength, a 2-piece linear spline was used in the REM with 1 knot fixed at age 75 years.9 To account for between-person heterogeneity in terms of individual deviation from the population mean trajectory, intercept (ie, grip strength at age 70 years, termed baseline strength henceforth) and age slope before age 75 years were modeled as random effects with an unstructured variance-covariance matrix.

Next, we performed joint analysis of the repeated measurements of grip strength and the time-to-event data using a method that has been previously published.10 The model assessed the effects of the rate of change in grip strength on the outcomes independent of baseline strength. For each outcome, analysis was restricted to women who were event-free at baseline and included only strength measurements up to the time of event onset or censoring. All analyses were adjusted for age, race, education, body mass index (BMI), number of chronic diseases, smoking status, physical activity, depressive symptomatology, and serum interleukin 6 and albumin, as in prior research.9 Statistical analyses were conducted in SAS (version 9.2; SAS Institute Inc, Cary, North Carolina).

Results. Of these 352 women included, 17% were African American and 70% were either overweight or obese. Their mean age was 74 years at baseline, with a mean 12.7 years of education. At baseline, 20% reported a history...