TREATMENT PATTERNS AMONG NEWLY DIAGNOSED CORONARY HEART DISEASE PATIENTS: CORRELATES OF LIPID MANAGEMENT

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OBJECTIVES: In support of secondary prevention efforts, NCEP guidelines have affirmed the importance of intensive management of LDL cholesterol in established CHD patients. The objective of this retrospective, cohort analysis was to examine correlates of “optimal” lipid management among newly diagnosed CHD patients. The population was drawn from a health benefits company under capitation (commercial, Medicare) and PPO arrangements. METHODS: Eligible subjects (N = 10,125) had an index medical claim for CHD in Year 2000 (ICD-9 CM codes of 410–414, Procedure codes of: 36.0–36.3), no such diagnostic codes during a previous 24-month “clean” period, no pharmacy claims for a lipid-lowering agent (LLA) in the six month period prior to the index diagnosis, and continuous enrollment during the 36-month observation period. “Optimal” management was defined as at least 1 claim for a LLA in all four quarters of a 12-month post-index follow-up period, coupled with at least 1 lab claim associated with lipid monitoring (lab values were not available for analysis). RESULTS: Patients classified as receiving “optimal” management equaled 4.9%, with 50.3% classified as receiving neither a lab claim nor a LLA. A logistic regression identified five statistically significant (P < 0.01) predictors of “optimal” management, including: a) identification by a diagnosis of acute MI; b) age < 65 years; c) male gender; d) a comorbidity of hypertension; and e) initial CHD diagnosis by a physician other than a cardiologist/cardiovascular surgeon. CONCLUSIONS: Effective lipid management in patients with CHD has been linked to reduced mortality, decreased morbidity and lower treatment costs. Nonetheless, study findings identify a large gap between the promise of pharmacotherapy and performance in clinical practice. Increased promotion of guidelines emphasizing the importance of aggressive lipid management for both physicians and patients may be necessary to decrease this gap and to achieve desired objectives of secondary prevention of CHD.

DISEASE MANAGEMENT REDUCES HEALTHCARE DISPARITIES IN HEART FAILURE PATIENTS

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OBJECTIVE: To provide evidence that a heart failure (HF) disease management (DM) program can reduce disparities in healthcare outcomes in minority populations. METHODS: The study sample included HF patients who were in a nurse-mediated DM program for at least 90 days, and who had a minimum of 2 quality of life (QOL) and 2 NYHA measurements. QOL was measured for both physical (PCS) and mental health (MCS) using the SF-8 survey instrument. QOL and NYHA were measured at the time of program enrollment and quarterly thereafter. Baseline QOL and NYHA scores were compared to the most recent. The 95% confidence interval for clinical significance is +/- 6.3 for MCS and +/- 5.7 for PCS. There were 2578 patients in the sample, of which 2081 were white and 497 were black. Blacks were significantly younger than whites (67 and 72 years of age), and were more female (61% and 52%). RESULTS: The mean PCS at baseline was 38.16 and 37.96, for whites and blacks respectively. The mean PCS for the most recent scores was 41.39 (p < 0.0001) and 42.01 (p < 0.0001) respectively for whites and blacks. Importantly, 39% and 45% of whites and blacks had clinically significant improvements in PCS. The mean MCS at baseline was 46.44 and 47.28, for whites and black respectively. The mean MCS for the most recent score was 47.84 (p < 0.0001) and 48.21 (p = 0.05) respectively for whites and blacks. Twenty seven percent of both groups had clinically significant improvements in MCS. At baseline, 45% of whites and only 35% of blacks were NYHA I or II. For the current measurement 57% of whites and 59% of blacks were NYHA I or II. CONCLUSIONS: Based upon these results, DM reduces healthcare disparities between white and black populations.

CARDIOVASCULAR DISEASES/DISORDERS—Economic Outcomes

A COST-BENEFIT MODEL FOR PERINDOPRIL IN SECONDARY STROKE PREVENTION

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The PROGRESS trial demonstrated the effectiveness of perindopril/indapamide in secondary stroke prevention (SSP). No existing economic study has incorporated these findings in a cost-benefit analysis. OBJECTIVES: The objective of this analysis was to evaluate the cost/benefit of perindopril/indapamide in SSP. METHODS: The model used a decision tree approach to estimate direct cost savings associated with SSP for a hypothetical cohort of 10,000 first stroke survivors from an HMO’s perspective (1 Mio covered lives) over a 3-year time period. Incidence estimates for 2nd stroke and healthcare utilization as well as pharmacoeconomic estimates are presented for each year and separated for the two major stroke types (ischaemic and hemorrhagic stroke). First, stroke incidence and transition probabilities for healthcare utilization were abstracted from the published epidemiology literature, incidence of second strokes from the