PHV28

VARIABILITY IN THE CRITERIA FOR EARLY SWITCH AND EARLY DISCHARGE IN COMMUNITY-ACQUIRED PNEUMONIA: A SYSTEMATIC REVIEW OF THE LITERATURE

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Strategies to achieve early switch from intravenous to oral antibiotics and early discharge (ES\(\Delta\)) for patients with community-acquired pneumonia (CAP) are implemented in an attempt to improve quality and efficiency of care. A systematic review of ES\(\Delta\) criteria has not been previously performed. OBJECTIVES: To assess differential features of ES\(\Delta\) criteria in the published literature. METHODS: We searched MEDLINE, HEALTHSTAR, EMBASE, COCHRANE COLLABORATION, and BEST EVIDENCE databases from 1980–1999 for CAP studies that included specific switch criteria or recommendations to switch on a particular day. Explicit inclusion and exclusion criteria were applied to titles, abstracts, and articles. Physician reviews were done in duplicate, with disagreement resolved by consensus. RESULTS: From 3666 titles identified, 305 abstracts were reviewed. Of 85 articles selected, 62 (73%) were retrieved and reviewed. We identified 12 prospective interventional CAP-specific studies. Switch criteria included: resolution of fever (67%), improving respiratory signs and/or symptoms (50%), ability to take oral medications (50%), normalization of white blood cell count (33%), “clinical stability” (NOS) (33%), minimal IV treatment (25%), hemodynamic stability (25%), no other sites of infection (25%), unaltered mental status (17%), and stable or improving radiographic findings (8%) (reviewer kappa, 1.0). Nine different criteria combinations were applied in the 12 studies. Four studies applied separate criteria for early discharge: care for comorbid conditions (75%), need for diagnostic work-up (25%), social needs (25%), and clinical stability during observation (25%) (kappa = 1.0). Three different discharge criteria combinations were applied in 4 studies. A specific post-switch antibiotic was recommended in 8 (67%) studies, specific day for switch (median, day 3) in 7 (58%) studies, and specific day for discharge (median, day 4) in 4 (33%) studies. CONCLUSION: Systematic review reveals that there is considerable variability in ES\(\Delta\) criteria, which may promote uncertainty regarding the interpretation of results from ES\(\Delta\) studies.

PHV30

COSTS AND OUTCOMES OF A RESPIRATORY SYNCYTIAL VIRUS PROPHYLAXIS PROGRAM IN A MEDICAID MANAGED CARE ORGANIZATION

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Respiratory Syncytial Virus (RSV) is a known cause of morbidity in premature infants, as well as those with bronchopulmonary dysplasia. OBJECTIVE: To measure the impact of a RSV prophylaxis program on pulmonary-related hospitalizations (PRH), average length-of-stay (ALOS), and cost/immunized member to a Medicaid managed care plan. METHODS: Through administrative claims we identified members at risk for RSV infection based on American Academy of Pediatrics (AAP) guidelines for RSV prophylaxis. Baselines were determined for PRH rate and ALOS for two seasons prior to intervention (N = 452). We identified 205 high-risk infants eligible for prophylaxis. Physicians were mailed a list of their eligible
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(pre-authorized) members and AAP guidelines for palivizumab prophylaxis. Physicians were asked to treat according to clinical judgement. We then compared PRH, ALOS, and costs (PRH, drug, and administration) between prophylaxed (N = 69) and non-prophylaxed (N = 136) high-risk children. PRH were defined based on ICD-9-CM discharge codes for RSV infection, bronchiolitis, pneumonia, bronchitis, asthma, and other abnormal respiratory conditions. Hospitalization costs were tallied at $1500/day. RESULTS: Overall PRH rate and ALOS were reduced from 35.2% and 12.9 days in the baseline period to 25.9% (P < 0.1) and 8.1 days (P < 0.05) respectively. Non-prophylaxed children consumed more resources (31.6% PRH, 8.7 ALOS) than prophylaxed children (14.5% PRH, 5.4 ALOS). Reductions from baseline PRH and ALOS were significant in the treatment group (P < 0.05 for each). Drug and administration costs of $286,725 saved $467,571 in expected costs had baseline rates continued ($2281/high-risk member, $6776/immunized member). CONCLUSIONS: Guideline dissemination and pre-authorizing RSV prophylaxis with palivizumab in a high-risk Medicaid population is an effective policy tool for reduction of associated PRH, ALOS, as well as costs.

Cancer Research PCN

OUTCOMES AND COSTS OF ACUTE MYELOID LEUKEMIA OVER ONE YEAR FOLLOWING DIAGNOSIS: AN ANALYSIS OF SEER-MEDICARE DATA
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The incidence of acute myeloid leukemia (AML) is growing among the elderly. However, data on the clinical outcomes and costs of this form of cancer are sparse. OBJECTIVE: To estimate rates of mortality and hospitalization costs in the first year following the diagnosis of AML among US Medicare beneficiaries 65 years of age and older. METHODS: This study was based on SEER-Medicare data files, which include a linkage between cancer registry data and Medicare administrative claims data for approximately 14% of cancer cases identified in 17 geographically diverse regions across the US. Patients initially diagnosed with AML between 1991 and 1993 were identified from SEER registry data and followed for one year. The use of chemotherapy was ascertained based on DRGs, and ICD-9-CM diagnosis and procedure codes. Costs of care were based on total Medicare hospital payments. RESULTS: A total of 1,391 patients with AML were identified. In the year following diagnosis, only 27% of these patients underwent chemotherapy treatment. The prognosis for AML was quite poor, with a median survival estimated to be 3 months (mean ± SD: 5.2 ± 5.1), and over 75% of patients having died within one year. The number of hospitalizations (mean ± SD) during the one-year follow-up was 1.95 ± 1.50, with corresponding Medicare inpatient payments of $23,670 ± $26,583. Average Medicare hospital payments varied only slightly by sex and race, and declined substantially by age (due to poorer survival). Patients who underwent chemotherapy had costs almost 3 times higher than those of other patients, but also lived an average of 3 months longer. CONCLUSION: AML among the elderly is associated not only with a poor prognosis, but also with substantial inpatient costs over the relatively few remaining months of life.

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