difficult. In traditional clinical trials challenges to completeness and accuracy of cost data and protocol-induced bias may reduce generalizability of results. "Real-world" trials are potentially useful but few have been conducted. With readily available claims data, the practical approach is to use cost-to-charge ratio to estimate the dollar value of consumed resources. This paper examines the characteristics and cost-to-charge ratio for CABG patients by hospital and department over time. **METHODS:** Premier data for 17,000 CABG patients from 187 US hospitals between 2002 and 2004 were used. Hospital cost-to-charge ratios were estimated with patient level total cost and charges at discharge and within each department. Cost-to-charge ratio by hospital type and location were assessed. **RESULTS:** Cost-to-charge ratios were not associated with hospital bed size although from 2002 to 2004, the ratios decreased ranging from 2% to 14% percent indicating improved efficiency for all hospitals. The cost-to-charge ratio disparity between teaching and non-teaching hospitals is shrinking over time (0.43 vs. 0.40 and 0.39 vs. 0.38 at year 2002 and 2004, respectively). The cost-to-charge ratio gap between urban and rural hospitals remains over time (0.48 vs. 0.40 at year 2002, 0.46 vs. 0.37 at year 2004). With regard to departmental cost-to-charge ratio, they differ greatly by hospital department and vary across hospitals. Except for anesthesia, for teaching hospitals departmental cost-to-charge ratios declined on average by 14% (4% to 28%) from 2002 to 2004. For non-teaching hospitals, changes over time were mixed. For urban hospitals, departmental cost-to-charge ratios had declining patterns similar to that of teaching hospitals. **CONCLUSIONS:** Cost-to-charge ratio for CABG patients varies by hospital type and these differences declined over time. Appropriate cost-to-charge ratios must be used in order to produce valid cost estimates.

PCV41

PROVISION OF DIET/NUTRITION AND EXERCISE COUNSELING FOR PATIENTS WITH DYSLIPIDEMIA BY AMBULATORY CARE PHYSICIANS IN THE UNITED STATES

Lee LJ, Nichol MB
University of Southern California, Los Angeles, CA, USA

OBJECTIVES: First, estimate the prevalence of diet/nutrition (DN) and exercise counseling (EC) in patients with dyslipidemia during ambulatory care visits in the United States. Secondly, compare the likelihood of receiving DN or EC across various patient and physician characteristics. **METHODS:** The National Ambulatory Medical Care Survey (NAMCS) data for 2000 and 2001 were merged to obtain cross-sectional nationwide estimates of DN and EC. Dyslipidemia patients were identified by ICD-9 codes (272.XX). Sampling weights were provided by the NAMCS and logistic regressions were used. **RESULTS:** A total of 29.6 million (2-year average) visits in the U.S. had a diagnosis of dyslipidemia (n = 1620). Provision of DN was greater than EC (37% and 25%, respectively). Men were statistically significantly more likely to receive DN and EC than women, after adjusting for race and age (OR = 1.2 and 1.3, respectively). After adjusting for race and gender, subjects aged 50–64 years were more likely to receive DN than any other age group and subjects aged 30–49 were more likely to receive EC than any other age group. Compared to whites, blacks were 30% and 10% more likely to receive DN and EC, respectively, after adjusting for age and gender. It was found that self-paying subjects were more likely to receive EC (OR = 1.2, p = 0.003) but less likely to receive DN (OR = 0.72, p = 0.0002) than subjects with private insurance. Physicians located in the West provided greater provisions of DN and EC when compared to physicians located in other parts of the United States (OR = 2.2 and 1.5, respectively).

Compared to internists or cardiologists, family medicine physicians provided more DN and EC (p < 0.0001). **CONCLUSION:** Over two years, provisions of DN and EC were relatively low. More efforts in providing these preventative measures are warranted.

PCV42

PREDICTING HIGH COSTS IN CALIFORNIA MEDICAID PATIENTS WITH CARDIOVASCULAR DISEASE (CVD)

Nichol MB[1], Dow T[1], Knight TK[1], Gause D[2], Wong KS[2], Yu AP[1]
[1]University of Southern California, Los Angeles, CA, USA, [2]Novartis Pharmaceuticals, East Hanover, NJ, USA

OBJECTIVES: To predict high-risk patients with cardiovascular disease (CVD) over a 1, 2, and 3 year time period. Good prediction models will enable health care providers to target high risk patients who would most benefit from intervention programs designed to improve CVD patient outcomes. **METHODS:** Using classification and regression tree (C&RT) analysis from AnswerTree (SPSS 3.0), risk models were developed using California Medicaid (Medi-Cal) medical and pharmaceutical claims data for 62,154 patients with a diagnosis of CVD. Variables defined for the 6-month pre-period were used to predict year 1, year 2, and year 3 total costs. To determine the predictive ability of the model, we designated high cost patients as those with total costs of greater than $10,000, and low cost patients as those with less than $10,000. **RESULTS:** Outpatient cost (of approximately $3600, >1 SD above the median) in the six months prior to diagnosis was the most common split. Other contributing factors were patient comorbidities, including Other Neurological Disorders (p < 0.01), Deficiency Anemias (p < 0.01), and Hypertension (p < 0.01). Results for years 2 and 3 were similar to year 1 findings. With further examination of the data, we found that the small group of high cost patients at Year 1 continue to be high cost patients in the subsequent years, although nearly 14.5% drop out at year 2 and 14.5% dropout from year 2 to year 3. 35% of the sample was correctly grouped into the high-cost branch, while 98% of the low-cost subjects were correctly grouped into the low-cost branch. **CONCLUSIONS:** C&RT is a useful method in predicting high risk patients. As demonstrated in this sample, patients incurring high costs were signaled through outpatient utilization, and were correctly identified with a sensitivity of 35% and a specificity of 98%.

PCV43

AN EMPIRICAL EVALUATION OF THE EXPECTED VALUE OF PERFECT INFORMATION

Lundy J, Davies GM, Cook JR
Merck and Co, Blue Bell, PA, USA

OBJECTIVE: The Expected Value of Perfect Information (EVPI) is becoming an increasing valuable tool to assist healthcare decision makers with their choices of new healthcare technologies. Although the use of EVPI in healthcare decision making is on the rise the study of its properties has received little attention. This study will evaluate the properties of the EVPI in the context of a currently published model for a cholesterol lowering therapy. **METHODS:** The properties of the EVPI were studied using a Markov chain model that evaluated the cost-effectiveness of ezetimibe co-administration with statin therapy vs statin titration (Cook et al. 2004). Simulations of the model were run for iterations of size 1000, 10,000 and 100,000. Baseline decisions were evaluated for blocks of 1000 iterations and the percent of correct optimal decisions as well as the mean and standard deviation for the net benefits were tabulated within each block. **RESULTS:** The estimated EVPI for 1000, 10,000 and