work is needed to determine whether interventions aimed at these patients will result in improved quality of life.

**PCV5**

**COST OF TREATMENT AND PREVALENCE OF CARDIOVASCULAR DISEASE COMORBIDITIES AND RISK FACTORS IN THE SEVERE AND PERSISTENTLY MENTALLY ILL**

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**OBJECTIVE:** It has been estimated that 92% of geriatric psychiatric patients have at least 1 comorbid physical disorder. The baby boomers will be turning 65 by 2011 and over 130 million people will be over 45 by 2050. The severe and persistently mentally population have not been extensively studied concerning comorbidities and physical and behavioral risk factors of cardiovascular disease. We propose to determine the cost of treatment and prevalence of these comorbidities and risk factors in this population.

**METHODS:** We conducted a chart review of all adult inpatients (N = 179) of a state psychiatric hospital during July and August 2000. All subjects had a medical history, physical exam, screening blood tests, ECG and medical service utilization data collected. The cost of treatment and prevalence of cardiovascular disease in our population was compared to a control group of Medicaid recipients matched for age and sex.

**RESULTS:** Subject Characteristics: 47 + 16 years; 113 male; 29% African American, 10% Hispanic, Cardiovascular Disease Comorbidities: 40% ECG abnormalities, 15% Hypertension, 10% Diabetes, 7% Thyroid Dysfunction, 6% CAD. Physical and Behavioral Risk Factors: 69% overweight (BMI > 25), 38% obese (BMI > 30); 18% hyperlipidemia, 67% nicotine & 49% alcohol abuse, 35% chemically addicted. Cost of Treatment: Total cost: $2539 ($2257–$2821), Cost of cardiovascular disease comorbidities: $3889 ($2105–$5673). CONCLUSION: 49% had cardiovascular disease comorbidities. 62% had multiple behavioral and physical risk factors for developing cardiovascular disease in their life time. The sample size limits our ability to make population inferences yet an association between severe and persistently mentally ill patients and a increased risk for cardiovascular disease exists in our group (T = −8.101, df = 356, P < .00001). This association is also evident in the greater cost of treatment $1985 ($1518–$2452) of the severe and persistently mentally ill compared to the control group (T = 4.78, df = 108, P < .00001).

**PCV6**

**ESTIMATING INCREMENTAL COSTS FOR ADDITIONAL HOSPITAL DAYS**

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**OBJECTIVE:** Methods to develop resource costs from administrative data remain underdeveloped. Our objective was to improve current methods of estimating daily hospitalization cost by determining the pattern of resource utilization for patients hospitalized with cardiovascular-related diagnoses. **METHODS:** Using a proprietary cost-accounting system, we assessed the proportion of total hospital costs for each hospital day for patients within 10 DRGs. From these proportions, a series of equations were developed to calculate cost for each day of hospitalization. The dataset for this analysis included records for 2,698 patients for FY 2000. **RESULTS:** 27.39% of costs occurred on Day 1 for medical DRG 127 (Heart Failure, ALOS = 5). For each of the remaining four days the proportion of cost was 18.15%, For surgical DRG 112 (PTCA, ALOS = 3), 65.56% of costs occurred on Day 1 and 17% occurred on each of the remaining two days. The average proportion of costs for the first day of hospitalization and for each day thereafter for the remaining medical and surgical DRGs were 30% and 17%, and 62% and 19%, respectively. To illustrate, the average cost per day of a DRG 112 hospitalization was $4,333, totaling $13,000. By using the developed equations, the cost for the first day of hospitalization was calculated to be $8,500. The cost for each remaining day was $2,238.60. In this example, use of an average cost per day overestimates the marginal cost of the last day by approximately $2,000. **CONCLUSION:** Average cost per day grossly overestimates the cost savings of reduced length of stay, especially for surgical diagnoses. The developed methodology will more accurately reflect any cost savings from a reduced length of stay by accounting for the greater intensity of care during the first day of a hospital admission.

**PCV7**

**COST-UTILITY ANALYSIS OF DRUG THERAPY OPTIONS FOR INTERMITTENT CLAUDICATION**

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Peripheral artery disease manifests as intermittent claudication in over 4 million people in the US. In people older than 60 years, intermittent claudication occurs in 5% of men and 3% of women. **OBJECTIVES:** The purpose of this study was to develop a cost-utility model to compare cilostazol, pentoxifylline, and placebo based on published randomized control trial data. **METHODS:** In the trial, 698 patients received either cilostazol 100 mg twice a day, pentoxifylline 400 mg 3 times a day, or placebo. Quality of life was measured with the SF-36. Survival was projected to be similar between the three groups from this study of 24 weeks duration and SF-36 was converted to a single utility score using the regression formula published by Bosch. **RESULTS:** On SF-36, cilostazol was significantly better on the physical components over baseline. Pentoxifylline and placebo were not significantly different on either the physical or mental compo-
nents over baseline. On the Bosch calculated single index, cilostazol was better than pentoxifylline and placebo. Pentoxifylline had a lower calculated QALY score than cilostazol or placebo. Based on this model, cilostazol had an incremental cost per QALY of $72,153 over placebo and $21,294 over pentoxifylline. As expected the model is sensitive to changes in price and utilities, and patients who have substantial improvements in QOL scores over baseline have better cost per QALY results. From a managed care perspective with a patient co-pay of 20%, the patient’s incremental cost of cilostazol over placebo was $14,431 per QALY and the managed care plan cost is $57,722 per QALY. CONCLUSION: Based on this analysis of treatments for intermittent claudication, cilostazol had a reasonable incremental cost per QALY over pentoxifylline or placebo. Lower cost per QALY results can be obtained by continuing on therapy patients who attain higher than average gains in quality of life scores from baseline.

**PCV8**

**PATIENT COMPLIANCE WITH DIFFERENT PRESCRIBED REGIMENS OF DILTIAZEM IN ANGINA PECTORIS: DATABASE ANALYSIS IN FRANCE**

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**OBJECTIVE:** Patient compliance is an important component in the successful management of any disease. In general, it is assumed that in disease states involving periodic, intense pain, such as angina pectoris (AP), compliance rates would be high, and unaffected by dosing regimen. We verified this hypothesis by examining the compliance rates of patients taking different formulations (o.d. (200–300mg), b.d. (90–120mg) and t.d.s. (60mg)) of diltiazem (princeps) for AP. **METHOD:** We performed a retrospective analysis of 3455 electronic patient records with a diagnosis of AP and a prescription of diltiazem (princeps) from June 1st 1997 to June 1st 1998 (Mediplus-IMS Health) with a one-year follow-up. The above patient cohort was then divided into 3 subgroups according to the different formulation taken. The two subgroups b.d. and t.d.s. were paired to the third one, according to 4 criteria: age, sex, disease history and comorbidities. Compliance was assessed using initial prescription and refill rates (pills dispensed/daily dose/duration of therapy). **RESULTS:** The proportion of patients showing “good compliance” (> 0.8) was significantly higher for the o.d. versus b.d. (36.1% versus 25.9%, p = 0.001) and for the o.d. versus t.d.s. (36.1% versus 27.1%, p = 0.008). We observed the same trend when we compared the mean rate of compliance for the o.d. versus b.d. (0.62 versus 0.55, p = 0.0027) and for the o.d. versus t.d.s. (0.62 versus 0.60, p = 0.0121). **CONCLUSION:** Even for life threatening cardiac disease like AP, dosing regimens have a significant effect on compliance. Giving diltiazem as an o.d. formulation could significantly improve compliance and potentially decrease health care resources used.

**PCV9**

**AN ECONOMIC ANALYSIS OF CONGESTIVE HEART FAILURE (CHF) IN THE LOUISIANA MEDICAID PROGRAM**

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**OBJECTIVE:** To examine the cost of illness of Congestive Heart Failure (CHF) in the Louisiana Medicaid program. **METHODS:** Study design: A retrospective review of the medical and pharmacy claims data (1999–2000) in the Louisiana Medicaid program. We reviewed pharmacy and medical claims data for the years 1999–2000 from the Louisiana Medicaid program. The data were obtained from Unisys, the fiscal intermediary for the Louisiana Medicaid program, in a PC compatible format. We extracted the claims for CHF patients on the basis of the ICD-9-CM codes. A total of 13,947 patients met the study criteria, which included at least one primary or secondary diagnosis of CHF and availability of claims data for at least one year after the first CHF diagnosis related claim. We reviewed all the charges incurred for a one-year period after the initial CHF claim. **RESULTS:** The total cost for CHF patients for one year was over $182 million. The majority of the patients (73.63%) were female and accounted for 70% of the total cost. The mean age was 70 years and the largest portion of the total cost (55%) came from those 65 years and older. Of the 13,947 patients 11,065 (79%) were hospitalized at an average cost of $4,679 per hospitalized patient. Approximately 87% of the study population received prescription drugs at an average cost of $2,897 per prescription drug user. Hospitalizations and prescription drugs contributed 28% and 19.38% respectively to the total cost. Almost one third of the total cost was due to long-term care at $13,817 per utilizer. Costs for CHF diagnosis related claims were 14% of all costs. **CONCLUSION:** CHF represents a significant financial burden from the perspective of the Louisiana Medicaid program. Improved management of the condition is needed to reduce the cost of treatment associated with CHF.

**PCV10**

**INCIDENCE OF RHABDOMYOLYSIS IN PATIENTS INITIATED ON HMG CO-A REDUCTASE INHIBITOR THERAPY IN A MANAGED CARE ORGANIZATION**

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Recent evidence suggests there is an increased risk of rhabdomyolysis in patients initiated on cerivastatin compared to patients initiated on other HMG CoA reductase