518, UK-504, France-483), under 122 cardiologists, mean age 62 (SD 12), mean weight 80 kg (SD 15), 22% female were recruited with co-morbidities of hypertension-53%, dyslipidemia-52%, diabetes-20% and prior MI-23%. Index diagnosis was: non ST-elevation ACS-62% and ST-elevation MI (STEMI)-38%. Admission and discharge use of medications were: aspirin-36 & 95%, clopidogrel-21 & 94%, statins-37 & 84%, beta-blockers-30 & 76% and ACE inhibitors/ARBs-34 & 67%. 2349 stents were used (DES-52%; France-33%, Spain-64%, UK-55%) with 58% of patients receiving only one. A total of 51% of patients were transferred at least once between study and another hospital, France-54%, Spain-46%, UK-54%. Admission to PCI at study hospital was: median 2 days (IQR 1–5 days) for non-ST ACS patients, (65% 3 days or less; France-87%, Spain-72%, UK-38%); and median 0 days (IQR 0–2 days) for STEMI patients, (73% 1 day or less; France-82%, Spain-74%, UK-58%). Total stay was median 6 days (IQR 4–9) for both cohorts. QoL at hospital discharge using EQ-5D health state index was: median 0.85 (IQR 0.71–1.00) with 1 representing perfect health. (France-0.85 (0.73–1.00), Spain-0.85 (0.73-1.00), UK-0.81 (0.68–1.00)). CONCLUSION: These data indicate geographic and case mix variation in management of ACS patients, including use of DES, but with uniform early QoL findings. Use of pharmacotherapies is high. Long term QoL will assess the impact of variations, but these early findings are useful benchmarks to guide service provision, focus treatment guidelines and validate clinical trials.

**PCV79**

**PHYSICIAN CHARACTERISTICS ASSOCIATED WITH STROKE RELATED OUTPATIENT CARE UTILIZATION: ANALYSIS OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY DATA, 2000-2005**

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OBJECTIVE: To assess trends in utilization of stroke-related outpatient physician services by physician specialty over the past 6 years. METHODS: This study was a retrospective analysis of the National Ambulatory Medical Care Survey (NAMCS) from 2000–2005. Ischemic stroke related visits in persons aged ≥45 years were identified using diagnosis codes (ICD9CM) 433.1x, 434.xx, and 436.xx. Visits per/1000 persons were calculated using United States population estimates. With logistic regression, we adjusted associations between stroke-related visits and physician type (Neurology, Primary Care, and Cardiovascular Medicine), for age, race, and region (Northeast, Midwest, West, and South), sex, diabetes, hypertension, insurance type, and survey year. RESULTS: From 2000 to 2005, stroke related outpatient physician office visits ambulatory care visits increased significantly from 4.7/1000 persons to 6.3/1000 persons (P Trend = 0.0001), a 131% increase. During the study period, the proportion of ambulatory stroke-related visits that were to a neurologist increased significantly from 15.5% in 2000 to 26.3% in 2005 (P Trend = 0.0001). However, during the same period, visits to primary care (2000: 74.4% vs. 2005: 67.8%), and cardiovascular medicine (2000: 10.0% vs. 2005: 5.9%) decreased. After adjustment, greater odds of stroke-related visits to neurologist (OR = 10.6 95% CI: 7.9–14.1) whereas no significant differences were observed for cardiovascular medicine (OR = 1.5 95% CI: 0.9–2.2) (Reference Category: Primary Care). CONCLUSION: From 2000 to 2005, stroke-related ambulatory physician visits increased significantly overall but particularly to neurologists. Secondary stroke prevention, historically performed by primary care physicians in the US, may be increasingly performed by neurologists. Given predictions for large rises in stroke prevalence due to the aging population and improved stroke survival, US demand for neurologists may be insufficient.

**PCV80**

**NATIONAL ESTIMATES OF ENROLLMENT IN DISEASE STATE MANAGEMENT PROGRAMS IN THE UNITED STATES**

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OBJECTIVE: Disease state management (DSM) programs are recommended for patients with conditions such as diabetes, hypertension, and hyperlipidemia. However, the level of adoption of these programs is not known. The objective of this study is to determine the level of utilization of DSM programs in the United States. METHODS: Data from the National Ambulatory Medical Care Survey (NAMCS), which includes a nationally representative sample of outpatient physician office visits, was used to meet the study objectives. In year 2005, NAMCS included an additional item regarding enrollment in DSM programs. Patients with diabetes, hypertension, or hyperlipidemia were identified and estimates for enrollment in DSM programs were computed. Logistic regression analysis was used to identify predictors of enrollment in such programs. Sample weights and the complex sampling design of the NAMCS were accounted for in all the analyses. RESULTS: The final study sample included 3,884 patient visits. Patients with diabetes had the highest rate of enrollment (24.6%), followed by patients with hyperlipidemia (20.4%) and hypertension (19.5%). Insurance status was an important predictor of enrollment status with patients enrolled in Medicare [Odds Ratio (OR) = 1.68; p = 0.021] and Medicaid [OR = 2.13; p = 0.008] significantly more likely to be enrolled in a DSM program as compared to those without insurance. Patients of Hispanic ethnicity were 67% less likely to be enrolled in a DSM program (OR = 0.33; p < 0.001). The only co-morbid condition that was a significant predictor of enrollment status was depression. Patients with co-morbid depression were 1.87 times more likely to be enrolled as compared to those without depression (OR = 1.87; p = 0.004). CONCLUSION: Although the benefits of DSM programs have been documented, their adoption rate remains extremely low. This study indicates that Hispanic ethnicity, insurance status and co-morbid depression were predictors of enrollment status. Additional studies are needed to identify other predictors and to tailor interventions to increase the adoption of such programs.

**PCV81**

**ASSESSING THE IMPACT OF INCORPORATING PATIENT KNOWLEDGE AND BELIEFS INTO ANTICOAGULATION THERAPY MANAGEMENT SERVICES**

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OBJECTIVE: The primary aim was to determine the impact on INR control resulting from the integration of information on patient health literacy and numeracy, health knowledge and health beliefs regarding warfarin therapy into the clinical information provided to the pharmacist. METHODS: A single-blinded randomized controlled study was conducted to test the hypothesis that including information on patient’s health literacy, numeracy, and anticoagulation knowledge and beliefs improves patient INR control. Patients were recruited from anticoagulation management services at the University of Maryland Medical Center and the Baltimore VA Medical Center.