In the past decade, the HMG CoA reductase inhibitors (HMGs) have revolutionized the treatment of hyperlipidemia. **OBJECTIVES:** The primary objective of this study was to determine the relationship between the use of HMGs and cardiovascular events in a diabetic hypertensive population from a managed care perspective. The secondary objective was to estimate any differences in overall health care costs (e.g., hospitalizations, emergency room visits, and pharmacy cost) between patients taking HMGs and those who are not. **METHODS:** Retrospective computerized claims from a managed care organization were analyzed (N = 6739). Patients were included if they had an ICD-9 diagnosis code for diabetes mellitus and hypertension between 9/1/95 and 8/31/96. During the identification period, patients who received an HMG were included in the HMG group. Patients who never received an HMG were included in the control group. All patients were followed for 3 years. **RESULTS:** In a multivariate regression analysis controlling for potential confounding factors such as age, gender, benefit design, disease severity, and number of comorbidities, pharmacy cost was higher in the HMG group (Beta = $1276, P = 0.0001). Use of the HMGs was associated with fewer emergency room visits (Beta = −0.387, P = 0.0001) and fewer inpatient days (Beta = −19.7, P = 0.0001). Logistic regression controlling for the same factors showed patients in the HMG group were less likely to experience death compared to the control group (odds ratio, 0.435; 95% confidence interval 0.365−0.517). **CONCLUSION:** The HMGs are associated with fewer emergency room visits, hospital days, and lowers the risk of death. The higher pharmacy costs associated with the HMGs appears to be offset by non-pharmacy cost savings.

**EVALUATION OF A DIABETES DISEASE MANAGEMENT PROGRAM IN A NURSING HOME**

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**OBJECTIVE:** To compare the impact of a diabetes disease management program (DDMP) in a V.A. nursing home. All diabetic patients residing as of September 1998 (pre-DDMP) were compared with those residing there in November 1999 (post-DDMP). Data collection included age, sex, types of diet, functional categories, weight, body mass index (BMI), cholesterol, hemoglobin A1C (HAI1C), urinalysis, eye and foot exams, and antidiabetic drug therapies. **RESULTS:** The pre-DDMP group had 31 males, mean age 76 years; post-DDMP group had 36 males, mean age 77 years. Eighteen men of the 36 men were in both the pre- and post-DDMP groups; the remaining post-DDMP group was admitted between study periods. Post-DDMP group had a higher average BMI (P < 0.01) and functional category (P < 0.04); attributed to the men admitted after starting the DDMP. Number of patients achieving HAI1C semi-annual testing criteria was statistically greater in the post-DDMP sample (30 pts (83%) vs. 13 pts (42%), P < 0.001). Mean HAI1C results were better in the post-DDMP sample (6.8% vs. 8.2%, P < 0.01). Post patients were more likely to have foot exams (P < 0.001). Changes in rates for urinalysis, cholesterol, and eye exam were not statistically significant. Twelve pre-DDMP patients were managed by diet alone; eleven in the post group. More post patients were managed by two or more drugs (P < 0.04) which was attributed to men admitted after starting the DDMP. **CONCLUSION:** Post-DDMP group had more HAI1C testing and better average results. A major observed change was in the increase usage of drug combinations which might be reflected in the observed improvement of glycemic control.

**OVERACTIVE BLADDER COST OF ILLNESS: ANALYSIS OF MEDI-CAL CLAIMS**

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**OBJECTIVES:** The primary objective of this study was to analyze the Medi-Cal 5% claims database in order to estimate the cost of illness for overactive bladder (OAB) to the California Medicaid program. Secondary objectives of this study were to describe patterns of care for patients diagnosed with overactive bladder and to discover cost offsets that could be achieved with drug treatment of OAB. **METHODS:** A continuously enrolled (1996–1997) cohort of overactive bladder patients was identified based upon the presence of ICD-9 diagnosis codes and drug claims in the database. All claims (physician, hospital, long term care, drug, and medical supply) for these patients were analyzed to determine the quantity and cost of services provided to patients with overactive bladder. Additional analyses were performed to determine if there were medical costs that could be offset by drug treatment of overactive bladder. **RESULTS:** Claims for OAB were analyzed for 97,160 unique patients. The prevalence of OAB in this continuously enrolled population was 2.95%, significantly lower that the National Survey of OAB estimate of 22%. The average direct costs per patient were $450 per year. Ninety-six percent of these costs were for incontinence pads and supplies. Only 13% of patients treated with oxybutynin continued therapy for more than 3 months. Patients treated with drug therapy alone or in combination with pads cost less to treat than patients receiving pads alone. Urologists ordered 95% of diagnostic tests. When OAB was diagnosed and treated, the number of claims and costs for comorbid urinary tract infections and skin breakdown decreased. **CONCLUSION:** Patients who receive drug treatment for...
OAB incur lower total costs for OAB management when the cost of incontinence pads are considered.

**PRN1**

**COST-EFFECTIVENESS OF BASILIXIMAB, DACLIZUMAB, AND OKT3 AS INDUCTION AGENTS IN KIDNEY TRANSPLANTATION**

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Basiliximab, daclizumab, and OKT3 are potent immunosuppressive induction agents used in kidney transplantation. All four agents have demonstrated statistically significant reductions in the incidence of acute rejection compared to standard therapy. However, the cost-effectiveness of these induction agents has not been studied in a uniform context or explored beyond a 1-year period following transplantation. OBJECTIVE: The purpose of this study is to estimate cost-effectiveness of basiliximab, daclizumab, and OKT3 compared to standard therapy over a 5-year period post transplantation using a societal perspective. METHODS: A Markov model was constructed using four states (eventfree, rejection/graft survival, graft failure/dialysis, death) to reflect the different clinical and economic states of transplant patients. The costs examined included initial hospitalization cost, acute rejection treatment cost, cost of graft failure and subsequent dialysis, cost of maintaining functional graft, and drug cost for induction agents. The transition probabilities and utilities were obtained from the randomized trials and other literature. Costs were obtained from the US Renal Data System Annual Report, the University Health System Consortium Pharmacy Database, the Red Book, and literature. RESULTS: Average costs for the first year post transplantation ranged from $58,052 to $78,153 and five-year total costs were estimated to be $154,806 (basiliximab), $155,712 (daclizumab), $181,113 (OKT3), and $166,124 (standard therapy). Daclizumab ($48,665/QALY) and basiliximab ($51,182/QALY) were more cost-effective than standard therapy ($56,646/QALY) or OKT3 ($60,391/QALY). CONCLUSION: Preliminary results suggest that daclizumab and basiliximab are cost-effective induction agents compared to standard therapy when considered over a 5-year period following transplantation. Extensive sensitivity analysis is planned to test the robustness of this finding.

**PRN2**

**COST ANALYSIS OF “OPTIMAL” US DIALYSIS MODALITY UTILIZATION**

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The prevalence of peritoneal dialysis (PD) in the USA is 12%. PD is less costly and as effective as hemodialysis (HD) for most patients. OBJECTIVE: To project savings from a shift in modality distribution (MD) to home-based therapies. METHOD: We developed a decision model to assess the cost impact of changes in MD, modality cost (MC) or numbers of patients. IPD was excluded. Using 1999 USRDS data, we calculated MC and applied patient numbers and MD. We previously surveyed US nephrologists who opined optimal MD to maximize survival: hospital HD 9.2%; community full care HD 33.9%; community self-care HD 13.8%; home HD 12.1%; CAPD 17.5%; APD 14.3%; and IPD 1.5%. To maximize cost-effectiveness the percentages changed to 4.2, 24.9, 15.5, 16.5, 26.7, 12.4, and 1.0% respectively. The estimated total dialysis spend, excluding epoetin and non-ambulance transportation, was generated and compared to the total cost using the “optimized” MD. RESULTS: A total dialysis spend of $11.25 billion was estimated using MD from the USRDS. The total savings and additional patients who could be treated at the MD opined for maximum survival was $750 million (6.7%) and 15,745, respectively; for maximum cost savings, $1.06 billion (9.5%) and 22,977. Survey limitations, costing assumptions and modeling suggest caution that the potential savings identified may or may not be completely achievable. CONCLUSION: Effecting a change in MD in accordance with what US nephrologists reported to be acceptable could lead to substantial Medicare savings. Strategies to increase utilization of home and self-care therapies, which might include earlier referral and empowerment of patient choice, should be considered.

**PRN3**

**ASSESSING QUALITY OF LIFE IN ROUTINE CLINICAL PRACTICE: A PILOT STUDY IN PATIENTS WITH RENAL DISEASE**

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OBJECTIVE: The objective of this study was to assess the feasibility and usefulness of administering a quality of life questionnaire within routine clinical practice with renal patients. METHODS: This was a national 5 centre study administering a disease-specific questionnaire, the Renal Quality of Life Profile (RQLP). The RQLP was administered by nurses to patients in addition to some demographic and open-ended questions. Nurses reviewed the completed questionnaire to identify potential areas requiring discussion and contacted the patient to discuss. RESULTS: The RQLP was administered to 140 patients: 24 predialysis, 12 home haemodialysis, 25 satellite haemodialysis, 21 hospital haemodialysis, 32 CAPD, and 26 transplant. 44% completed the questionnaire in the waiting room, 22% in the consulting room, and 34% on dialysis or at home. During questionnaire review, nurses felt