plications were derived from the DCCT, Framingham, and WESDR studies. Clinical input was taken from the 26-week multicenter, multinational, open-label trial. Costs were retrieved from published sources. Direct and indirect costs of diabetes complications and treatment with IDet/IAsp or IGlar/IAsp were projected over patients’ lifetimes from a societal health care perspective. Costs and outcomes were discounted at 3.5% annually. RESULTS: In this analysis, a reduction in major hypoglycemic events associated with IDet/IAsp led to an increase of quality-adjusted life expectancy of 0.11 quality-adjusted life years (QALYs). Direct lifetime costs were slightly higher with IDet/IAsp treatment than with IGlar/IAsp treatment, leading to ICURs of €21,453 per QALY gained in Austria and €13,607 per QALY gained in Germany. When indirect costs were included in the analysis, IDet/IAsp was dominant to IGlar/IAsp in both countries. CONCLUSIONS: IDet/IAsp therapy was associated with improved quality-adjusted life expectancy, leading to an ICUR based on direct costs that was well within the range considered to represent good value for money in Austria and Germany.

COST-UTILITY ANALYSIS IN A USA SETTING OF SCREENING AND OPTIMIZED TREATMENT OF NEUROPATHY IN HYPERTENSIVE PATIENTS WITH TYPE-2 DIABETES
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OBJECTIVES: Forty percent of hypertensive type-2 diabetes patients will develop nephropathy, indicating end organ damage, increased risk of cardiovascular disease (CVD), and death. In the US, screening rates and nephropathy treatment are suboptimal. We assessed the health economic impact of nephropathy screening followed by optimal antihypertensive therapy in those who have nephropathy in the US. METHODS: A Markov/Monte Carlo model simulated lifetime impacts of screening for nephropathy using semi-quantitative urine dipsticks in a primary care setting, and subsequent addition of irbesartan 300mg to conventional antihypertensives in hypertensive type-2 diabetes patients in those patients identified as having nephropathy. Progression from no renal disease to end-stage renal disease (ESRD) was simulated. Probabilities, utilities and costs of CVD events, medications and ESRD treatment came from published sources. Number of days of ESRD avoided, quality-adjusted life years (QALYs) and direct costs were projected. Second-order Monte Carlo simulation was used to account for uncertainty in multiple parameters. Costs and QALYs were discounted three percent annually. RESULTS: Screening followed by optimized treatment led to 36,683 ± 5767 days of ESRD avoided in 1000 simulated patients, with incremental costs per QALY gained of $7315. There was a 98% probability that screening and optimized antihypertensive therapy would be considered cost-effective with a willingness to pay ≥$20,000. Sensitivity analysis showed that screening and optimized treatment would dominate “no screening” in patients <55 years of age. CONCLUSIONS: In hypertensive patients with type-2 diabetes, screening for albuminuria followed by optimal antihypertensive treatment is cost-effective in a US setting.

IMPROVING DIABETES CARE MANAGEMENT ACROSS A SET OF COMPREHENSIVE MEASURES IN A MEDICAID MANAGED CARE ORGANIZATION
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Diabetes Mellitus is a significant public health problem in the United States. Monitoring of glycemic status, eye exam, LDL-C levels, and nephropathy testing is essential for diabetes care. OBJECTIVES: To improve diabetic care within a Medicaid Managed Care Organization. METHODS: This is a prospective interventional, pre- and post comparison study with retrospective claims data and medical chart review. Four indicators: HbA1c, LDL-C, eye exam, and nephropathy monitoring were targeted for quality improvement interventions. A random sample of 411 diabetic members aged 18–75 years was selected using administrative and medical records. Patient demographics, past medical history, eye exam, and laboratory data were recorded using a standard form. Patient and provider interventions included: case manager phone outreach program to remind
Abstracts

PDB44

USE OF ACETYL-SALICYLIC ACID FOR CARDIOVASCULAR PREVENTION IN PRIMARY CARE PATIENTS WITH DIABETES MELLITUS

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OBJECTIVE: Use of acetyl salicylic acid (ASA) for primary prevention (PP) and secondary prevention (SP) of cardiovascular disease (CVD) in adult diabetic patients is highly recommended. This study was conducted in order to determine the use of ASA and to assess the achievement of therapeutic targets in diabetic patients.

METHODS: This is a retrospective and observational study. Sample consisted of patients >18 years with diabetes mellitus followed in four primary care centers. Measurements included demographics, use of ASA and/or anticoagulant drugs, co-morbidities, clinical parameters and proportion of patient at therapeutic target (TT). Descriptive statistics, chi-square test and logistic regression model were used for significance.

RESULTS: A total of 4140 diabetic patients were analyzed, 79.1% (95% confidence interval: 77.7%–80.5%) in PP and 20.9% (18.2%–23.7%) in SP. Mean age was 64.1 (13.8) years, and 49.3% of patients were men (PP: 46.3; SP: 60.7; p = 0.000). ASA were prescribed on a routine basis in 29.2% (27.8%–30.6%); 20.8% (19.4%–22.2%) in PP and 60.8% (57.6%–64.0%) in SP. Proportion of patient at TT was 48.0% for hypertensives and 59.8% for hypercholesterolemic, being these the most frequent antecedents observed in SP. Older patients [OR = 1.01 (1.00–1.02); p = 0.011], number of cardiovascular-risk factors [OR = 1.14 (CI: 1.03–1.27); p = 0.013], LDL-c TT [OR = 1.42 (1.06–1.88); p = 0.017], and a poor metabolic control of glycated hemoglobin [OR = 1.51 (1.22–1.89); p = 0.000] were covariates associated to the use of ASS in PP.

CONCLUSIONS: Treatment with ASA is underused for PP in patients with diabetes mellitus in Primary Care. Achievement of TT should be improved.

PDB43

SHOULD WE LOOK FOR A NEW APPROACH IN DIABETES MELLITUS (DM) MANAGEMENT? IS IT A COST-EFFECTIVE STRATEGY IN THE POLISH SETTING?

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The high prevalence of undiagnosed diabetes and the large proportion of individuals with complications at diagnosis (50% according to UKPDS 33) argue for screening for Type-2 diabetes. The NHANES study confirms the substantially higher risk of death, lower survival, and lower life expectancy of diabetic adults compared with non-diabetic adults. A UK Prospective Diabetes Study shows that intensive blood-glucose control can reduce risk of any diabetes-related death and any diabetes-related endpoints.

OBJECTIVE: The aim of the study was to assess cost-effectiveness of active screening for DM and intensive blood-glucose control in comparison with conventional treatment in patients with DM II in the Polish population.

METHODS: The Markov model of DM progression to stimulate lifetime and related health care cost was constructed. Demographic characteristics of a stimulated cohort as well as cost of health care were based on a CODIP study population. Costs were analysed from a societal viewpoint and included only direct medical costs. Costs of active searching for DM and the distribution of people on diagnostic pathways came from an epidemiological Screen-Pol 2 study. The age-dependant risk of death and transition probabilities between disease stages were obtained from the NHANES study. The effectiveness of active blood-glucose control was derived from the UKPDS 33.

RESULTS: In the long term (20 years), a strategy based on active blood-glucose control could bring an additional 0.4 life years saved (LYS) per patient. An additional LYS costs €457. If active blood-glucose control is preceded by the active screening for DM, this strategy could bring 0.71 LYS per patient. The cost-effectiveness ratio amounts to €108,633/LYS.

CONCLUSIONS: The most effective strategy in DM management is based on an early detection program and active blood-glucose control. The cost-effectiveness ratio for active glucose control is extremely low.

PDB45

PREDICTORS OF DIABETES MEDICATION UTILIZATION AND HEALTH CARE COSTS IN U.S. PATIENTS WITH TYPE-2 DIABETES: RESULTS FROM A NATIONAL SURVEY STUDY

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OBJECTIVE: This study determined the predictors of antidiabetes medication adherence and health care costs in adults with Type-2 diabetes mellitus in the United States. METHODS: The 2000 Medical Expenditure Panel survey was used for the analyses. The population for analyses was identified using ICD-9 CM codes for Type-2 diabetes. The predictor variables were demographics variables, self-reported health status (EuroQol score), and health services utilization variables. The dependent variables in this analysis were diabetes medication possession (number of diabetes medication refills) and annual health care costs. Multivariate weighted analysis was performed to identify significant predictors of medication utilization and health care costs.

RESULTS: There were 11.7 million patients with reported Type-2 diabetes in the United States in 2000, based on survey extrapolation. On an average, there were ten diabetes drug refills reported by patients. The average annual health care costs for these patients were $7466, while the mean EuroQol summary score was 48%. Increase in the health status summary score (EuroQol) by 10% was associated with a slight (1%) decrease in diabetes drug refills (p < 0.05). An additional diabetes related emergency visit or an inpatient visit was associated with a nearly 50% increase compared to the average diabetes medication util-