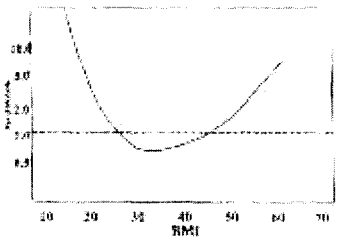
ever, patients with BMI >25 are at increased risk of recurrent AMI. This finding suggests the need to aggressively intervene in obese and overweight patients following the index AMI to reduce the long-term risk of recurrent events.



1193-58 **What Is the Meaning of High-Risk? A Prospective Comparison of Three Risk Stratification Models Recommended in Non-ST Elevation Myocardial Infarction and Unstable Angina**

Ali F. Sonel, Chester B. Good, Mary E. Kelley, Lauren Wall, Jeffrey Whittle, Michael J. Fine, VA Pittsburgh Healthcare System, Center for Health Equity Research and Promotion, Pittsburgh, PA, University of Pittsburgh, Pittsburgh, PA

Background: Non-ST elevation MI (NSTEMI) and unstable angina (UA) patients (pts) represent a heterogeneous population. ACC/AHA guidelines for NSTEMI and UA recommend 3 different risk stratification models (AHCPR, PURSUIT, TIMI).
Methods: The relative accuracy of each risk model cited by the guidelines was prospectively studied in 566 pts admitted with suspicion of MI. Information was obtained from chart review and clinical follow up. The end-point was 30-day death or new MI.
Results: Mean age was 67 +/- 12 years. The AHCPR Model, PURSUIT Model and the TIMI Model identified 85%, 42% and 9% of pts as "high-risk" respectively. Using only cardiac marker and ECG criteria, 63% of pts were identified as high-risk. At 30 days 58 of 566 patients (10%) had a cardiac event. Among all three model variables, hemodynamic instability (p<0.001), pulmonary edema (p<0.001), cardiac markers (p<0.001), age (p=0.035), ST changes (p=0.05), Canadian Cardiovascular Class III-IV (p=0.036), not being on aspirin prior to admission(p=0.015) were predictive of events.

	% Event High-Risk	% Event Not High-Risk	Sensitivity	Specificity	*p* value
AHCPR Model	11%	4%	95%	10%	0.031
PURSUIT Model	14%	8%	57%	60%	0.016
TIMI Model	10%	10%	9%	91%	NS
ECG and Markers	14%	4%	85%	39%	<0.001

Conclusions: Although both the AHCPR Model and the PURSUIT Model were predictive of events, the former was non-specific. A model based only on the ECG and marker criteria predicted events with good sensitivity and moderate specificity. The TIMI Risk score was not predictive of events. Future models for risk stratification should rely more on objective markers and ECG criteria and should be derived and validated prospectively in a non-selected population of pts.

ORAL CONTRIBUTIONS

851 Societal Issues in Outcomes Research

Tuesday, April 01, 2003, 2:00 p.m.-3:30 p.m.
McCormick Place, Room S105

2:00 p.m.

851-1 **Effect of Ethnicity on Distrust Toward Medical Researchers and Willingness to Join a Cardiovascular Drug Prevention Trial**

Joel B. Braunstein, Steven P. Schulman, Neil R. Powe, The Johns Hopkins Medical Institutions, Baltimore, MD

Background: Minority underrepresentation exists in medical research including cardiovascular disease (CVD) clinical trials. We asked whether African-Americans (AA) differ from Caucasians (C) in their distrust toward medical researchers and whether this influences their willingness to participate (WTP) in a clinical trial.
Methods: We approached 717 randomly selected patients from 13 Maryland-based outpatient cardiology and general medicine clinics between May and August 2002 to complete a self-administered survey regarding their WTP in a CVD drug prevention trial. Patients read a trial description that contained information similar to that in a consent form and reported their WTP using a 5-point scale. Medical researcher distrust was assessed using a previously published 7-point index. We determined the relation between ethnicity and distrust, and how these factors influenced WTP, while adjusting for sociodemographics.
Results: 595 patients (83% response) completed the survey: mean (SD) age = 53.6 (15.6) yrs, 54% female, and 37% AA. AA had higher mean distrust scores than C patients (2.6±1.7 vs. 1.5±1.5, p<0.0001). AA more often reported that doctors would less fully explain research to them (25% vs. 13%, p<0.001), use them as guinea pigs without consent (73% vs. 50%, p<0.001), prescribe medication as a way of experimenting on people without their knowledge (59% vs. 26%, p<0.001), and ask them to join research even if it could harm them (26% vs. 16%, p=0.003). AA also more often believed they could less freely ask their doctor questions (8% vs. 2%, p=0.001) and were previously experimented on without their consent (55% vs. 45%, p<0.001). Fewer AA than C were WTP (29% vs. 38%, respectively, p=0.03); however, this difference was no longer significant after controlling for distrust and sociodemographics (OR=0.82, 95% CI 0.55-1.22). Every one-point increase in distrust score predicted a 27% lower odds of WTP, OR=0.73 (0.65-0.83, p<0.001).
Conclusion: AA express much greater distrust toward medical researchers, and distrust is an important negative predictor of WTP in clinical trials. Greater distrust toward medical researchers may partially explain AA underrepresentation in clinical trials.

2:15 p.m.

851-2 **Ramifications of Cost-Sharing for 21,732 Patients With Congestive Heart Failure: Early Results From the Safety and Financial Ramifications of Emergency Department Copayments (SAFE) Study**

John Hsu, Mary Price, Richard Brand, Bruce Fireman, Joseph P. Newhouse, Joseph V. Selby, Kaiser Foundation Research Institute, Oakland, CA, Harvard University, Cambridge, MA

Background Millions of Americans are facing increasing levels of cost-sharing, which are designed to promote more efficient resource use, but have unclear clinical consequences. We investigated the impact of cost-sharing for emergency care on Emergency Department (ED) visits and hospitalizations in a cohort of patients with congestive heart failure (CHF). **Methods** As part of an AHRQ-sponsored quasi-experimental study, we examined the effect of ED copayment levels on ED visits and hospitalizations during 1999– 2001 in adult congestive heart failure (CHF) patients. All subjects were members of Kaiser Permanente–Northern California, an integrated, managed care delivery system. We classified ED copayments of $20 or greater as High, and compared the estimated relative rates of monthly ED use and hospitalizations by copayment level using a gamma random effects model, adjusting for age, gender, medical center, a case-mix propensity score, baseline cardiovascular medication use, and time. We used the 118 hierarchical condition categories (DxCG based HCC's) to calculate the propensity score. **Results** The 21,732 subjects tended to be male (55%) and 65 years or older (74%; mean age 71 years, SD=12). In 1999, 14% of subjects had High ED copayments; this percentage increased to 60% in 2000 and 70% in 2001. The number of patients with Medicare remained around 67% during the study period; the remainder had commercial prepaid insurance. The mean ED visit and hospitalization rates were 132.2 and 57.8 visits per 100 person-months respectively. In the multivariate models, subjects with a High ED copayment had a relative ED visit rate of 0.97 (95% CI: 0.95 – 0.99), and hospitalization rate of 1.0 (95% CI: 0.97 – 1.05). **Conclusion** In chronic disease patients, copayments for ED visits were associated with a small decrease in ED use, but were not associated with significant changes in hospitalizations. These preliminary data suggest that cost-sharing for emergency care could reduce resource consumption and costs without harming patients' health. Additional analyses will investigate changes in other clinical outcomes including mortality and in total costs.

2:30 p.m.

851-3 **Influence of Physician Specialty on Care and Outcomes of Acute Coronary Syndrome Patients: Results From CRUSADE**

Eric D. Peterson, Matthew T. Roe, Yun Li, Robert A. Harrington, Ralph G. Brindis, Sidney Smith, W. Brian Gibler, E. Magnus Ohman, Duke Clinical Research Institute, Durham, NC

Background: We investigated the degree to which care of patients with NSTE acute coronary syndrome (ACS) varies by the speciality of the primary treating physician. We also associated these care differences with acute patient outcomes. **Methods:** Using the CRUSADE National Registry, we examined 18,985 high risk ACS pts with + cardiac markers and/or ST depression treated at 289 US hospitals in 2001-02. We compared 12 class I ACC/AHA guideline care processes, as well as, in-hospital outcomes by the MD primarily responsible for in-hospital care (cardiology vs non-cardiology). Care and outcome results were also adjusted for patient casemix and for hospital features (academic status, hospital facilities, bed size and % pts treated by cardiology). **Results:** Overall, 43% of ACS patients were primarily cared for by non-cardiologists. Table 1 provides selected care processes and outcomes by speciality and the adjusted odds ratio for receiving that treatment or outcome for cardiologists' care vs not. **Conclusions:** Patients with NSTE ACS were significantly more likely to receive ACC/AHA guidelines indicated treatments if they were cared for by a cardiologist. Patients' acute mortality risks was also significantly lower with cardiologist care even after adjusting for presenting clinical factors and hospital features. This study demonstrates the need to more widely disseminate national cardiac care guidelines for NSTE ACS to all physicians.