Abstracts

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READMISIONS AFTER UNAUTHORIZED DISCHARGES IN THE CARDIOVASCULAR SETTING
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OBJECTIVES: Patients who self-discharge against medical advice (AMA) may be at higher risk of readmission if the unauthorized discharge was premature. The study objective is to examine the relationship between discharges AMA and cardiovascular disease (CVD) hospital readmissions while addressing bias due to potential confounding, selection, and hospital-level clustering. METHODS: This cross-sectional study uses confidential patient hospital discharge data from 2000 to 2005. The outcome variables captured readmissions for a CVD-related condition following an index CVD-related admission. The covariate of interest was an indicator variable for a discharge AMA in the index hospitalization. The relationship between discharges AMA and readmission was evaluated using logistic regression with adjustments for clustering and selection bias. RESULTS: The sample included 443,088 patients, of which 22,757 (5.1%) were readmitted to the same hospital. Approximately 1% of the patients who were readmitted in the hospital during the study period left AMA on the index admission while 0.89% of those who were not readmitted left AMA (p = 0.047). The odds of a CVD-related readmission within 7 days, 31 days, 180 days and 365 days were 145% (p < 0.001), 55% (p < 0.001), 26% (p < 0.001) and 15% (p = 0.0011) higher for patients discharged AMA on index admission compared to those who were discharged formally. Results are robust to corrections for observable selection bias (via propensity score analysis) and hospital-level clustering. CONCLUSIONS: A self-discharge AMA among patients admitted for CVD is predictive of CVD-related readmissions and the strength of association increases as the time between admissions decreases.

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TREATMENT PATTERNS IN ATRIAL FIBRILLATION: AGENTS USED IN CURRENT PATIENT MANAGEMENT
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OBJECTIVES: Future refinement of pharmacotherapy of atrial fibrillation/atrial flutter (AF) requires a detailed understanding of how treatments are currently employed in clinical practice. METHODS: In this retrospective cohort study, we used the US MarketScan® database to identify patients ≥18 years with AF (≥1 AF inpatient or ≥2 outpatient AF claims) and ≥18 months’ continuous enrollment data between Jan 2003 and Mar 2007. The first qualifying AF diagnosis (based on AHRQ criteria) was designated the index diagnosis. AF was classified as newly-diagnosed (ND) or pre-existing (PRE), based on treatment history in the pre-index period. RESULTS: Of 184,115 identified patients (mean age 73 years, 55% men), 64,669 had ND and 119,886 had PRE AF. Non-pharmacotherapy for AF was undertaken in 11% of patients with ND vs 6% of patients with PRE disease, most commonly cardioversion (9% vs. 4% of patients, respectively). Across both patient groups, 30% received no drug therapy within 30 days of initial AF diagnosis (inpatient treatment), 17% received antiarrhythmics (rhythm-control agents), 51% rate-control agents, 40% anticoagulants, and 5% antplatelets (aspirin use was not captured). Median duration of uninterrupted initial therapy was 210 days for antiarrhythmics and antplatelets, 228 days for anticoagulants and 420 days for rate-control agents. Over the entire post-index follow-up period (mean 20 months), ND and PRE AF patients received antiarrhythmics (27% vs 28%), rate-control agents (77% vs 76%), anticoagulants (54% vs 66%) and antplatelets (14% vs 10%). Overall, the most commonly used drugs were amiodarone (15%), β-blockers (56%), calcium channel blockers (23%), cardiac glycosides (35%), warfarin (61%) and clopidogrel (81%). CONCLUSIONS: Non-pharmacological interventions for AF were relatively uncommon. Almost one-third of AF patients in our study remained untreated for the first 30 days after diagnosis, which may represent under-treatment. Rate-control agents and anticoagulants were used more frequently than antiarrhythmics and antplatelets for treatment of AF.

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PRIORITY-SETTING FOR COMPARATIVE EFFECTIVENESS RESEARCH
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OBJECTIVES: Coincident with the increasing focus on comparative effectiveness research (CER), a number of organizations have begun to engage in prioritizing topics for CER. This paper presents the priority-setting process developed by the Center for Action on Medical Technology Policy (CAMP) and its application to the selection of priority topics for cardiac technologies. METHODS: We reviewed criteria and processes used by other organizations. We then developed a multi-stage process including, 1) horizon setting, 2) identification of topics, 3) expert scoring, 4) consensus development, and 5) final ranking of topics for varied research projects. After internally refining a broad list to the ten technologies, we convened an expert workgroup charged with ranking these top technologies using prospectively developed criteria. Experts were provided with a list of criteria and brief summaries of clinical, economic, and ethical aspects of each technology. RESULTS: Topic nomination produced an initial list of approximately 40 technologies, which were narrowed to the top ten based on suitability for CAMP’s coverage with evidence development (CDE) initiatives and guidelines.