CONCLUSION: Selection of appropriate second-line therapy should be based on coverage and local cross-resistance patterns.

**PATIENT TREATMENT ACCORDING TO PRACTICE GUIDELINES IN COMMUNITY HOSPITALS COMPARED TO TEACHING HOSPITALS IN THE COMMUNITY-ACQUIRED PNEUMONIA (CAP) PROJECT**
Chaikledkaew U¹, Hopefi A², Goad JA¹, Kamath TV³, Johnson KA¹
¹University of Southern California, Los Angeles, CA, USA; ²AmeriNet, St. Louis, MO, USA; ³Bristol-Myers Squibb, Princeton, NJ, USA

OBJECTIVES: To compare patient treatment according to practice guidelines and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) outcome measures by hospital type. To investigate various factors associated with patient treatment according to guidelines.

METHODS: Data from 2,238 patients with CAP were collected from 61 hospitals during a 3-month period. Patient data included demographic, antimicrobial selection, and outcome data. Univariate/multivariate statistical analyses were conducted.

RESULTS: Compared to teaching hospitals, a significantly higher percentage of patients admitted to community hospitals received treatment in accordance with treatment guidelines (84% versus 78%). Patients admitted to community hospitals received treatment according to the 1993 American Thoracic Society (ATS) guidelines (53% versus 46%), whereas patients admitted to teaching hospitals received treatment according to the Centers for Disease Control and Prevention guidelines (CDC) (27% versus 21%). A patient level logistic regression analyses showed that admission to community hospitals (odds ratio; OR = 1.9, p < 0.001), hospitals with a CAP care plan (OR = 1.5, p < 0.01), and higher severity of illness score (OR = 1.1, p < 0.002) were significantly associated with receiving care according to practice guidelines. However, patients admitted to the ICU (OR = 0.04, p < 0.001) and having a neoplastic disease comorbidity (OR = 0.45, p < 0.0002) or congestive heart failure (OR = 0.68, p < 0.021) were significantly less likely to receive treatment according to guidelines. Admission to a small, medium or large hospital had no significant effect on receiving treatment according to guidelines. Finally, there was no significant difference between hospitals in terms of data collection for JCAHO Core Performance Measures.

CONCLUSIONS: Most patients with CAP are prescribed antimicrobial drug therapy concomitant with the guidelines and hospitals are variably collecting data that will help achieve the JCAHO core performance measures. Patients admitted to community hospitals receive treatment in accordance with CAP guidelines more often than patients admitted to teaching hospitals, controlling for other factors that impact patient treatment choice.

**THE IMPACT OF PHYSICIAN REPORTED RISK FACTORS ON HOSPITALIZATION RATES FOR INFANTS ON PALIVIZUMAB THERAPY**
Marks AS, Berger J, Slezak J, Johnson KE
Caremark, Inc, Northbrook, IL, USA

OBJECTIVES: To identify the relationship of physician reported risk factors to the incidence of hospitalizations after the initiation of Palivizumab (Synagis TM) therapy for first season prophylaxis to respiratory syncytial virus (RSV).

METHODS: Participants from Caremark’s specialty pharmacy database who initiated Palivizumab therapy for the 2001–02 season were analyzed on physician reported risk factors prior to therapy initiation for one large payer. These risk factors include, respiratory related hospitalizations, older siblings, multiple births, exposure to smoke, chronic illness diagnosis, medical treatment, daycare and unspecified risk. We assessed the proportion of risk factors within the population at the initiation of therapy for first season infant exposure. The relationship between these risk factors and post-therapy initiation hospitalization rates will be assessed using multivariate analysis. The study period was for participants born after 01 April 2001.

RESULTS: 410 participants (age = 156 +/- 63 days) who presented prescriptions for Palivizumab through Caremark’s Specialty Pharmacy for the 2001–2002 RSV season were analyzed. On average, infants had 1.23 +/- 1.05 risk factors. We identified 4.15% of the infants had a reported respiratory hospitalization prior to therapy initiation for one large payer. Risk factors prior to therapy initiation were distributed as follows: 33.9% Older Siblings, 30.24% Multiple Births, 7.07% Exposure to Smoke, 5.37% Chronic Illness Diagnosis, 22.2% Medical Treatment, 10.0% Daycare Exposure, and 14.39% Unspecified Risk. Post therapy initiation hospitalization rates for the 2001–2002 RSV season are currently being collected and results of the multivariate analysis will be presented.

CONCLUSION: A priori variables to direct and optimize therapeutic management of at-risk RSV infant populations are essential. These findings on hospitalization rates associated with physician reported risk factors would support the decision making of both pharmacy and provider organizations.

**WHAT IS THE VALUE OF WARD SUPPLY DATA FOR MONITORING ANTIBIOTIC USE IN HOSPITAL?**
Ofori BD¹, Davey PG²
¹Ninewells Hospital and Medical School, Dundee, UK; ²University of Dundee, Dundee, UK

METHODS: Participants from Caremark’s specialty pharmacy database who initiated Palivizumab therapy for the 2001–02 season were analyzed on physician reported risk factors prior to therapy initiation for one large payer. These risk factors include, respiratory related hospitalizations, older siblings, multiple births, exposure to smoke, chronic illness diagnosis, medical treatment, daycare and unspecified risk. We assessed the proportion of risk factors within the population at the initiation of therapy for first season infant exposure. The relationship between these risk factors and post-therapy initiation hospitalization rates will be assessed using multivariate analysis. The study period was for participants born after 01 April 2001.

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CONCLUSION: A priori variables to direct and optimize therapeutic management of at-risk RSV infant populations are essential. These findings on hospitalization rates associated with physician reported risk factors would support the decision making of both pharmacy and provider organizations.