therapy increased significantly for physicians in the intervention group compared to physicians in the control group during the post-intervention period \( (P = 0.02) \). This increase in eradication utilization was not accompanied by a significant increase in the total cost of drug therapy per patient for the intervention group compared to the control group \( (P = 0.82) \). The results from a 9-month follow-up period will be presented. CONCLUSIONS: The main goal of the study, to increase the utilization of eradication therapy, was achieved in the 3-month follow-up period. Observable modification of physician behavior in only a three-month period is a positive finding, and may indicate an even greater impact when the program is evaluated over a longer period of time.

**THE CLINICAL AND ECONOMIC IMPACT OF COMPETING MANAGEMENT STRATEGIES FOR GASTROESOPHAGEAL REFLUX DISEASE (GERD)**

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**OBJECTIVES:** The optimal management strategy for patients with symptoms of GERD remains undefined. Our objective was to examine the clinical and economic impact of competing management strategies. **METHODS:** Decision analysis was used to compare a traditional “step-up” strategy with sequential invasive diagnostic testing as needed to a strategy utilizing the initial “PPI test” followed by a “step-down” approach with sequential diagnostic testing as needed. The cost per symptom-free patient was assessed at 1-year. Systematic literature review, Medicare payments and drug AWPs were used to derive probability and cost estimates for the model. Where there was uncertainty in the literature, estimates were chosen to bias the model in favor of the traditional strategy. Where there was uncertainty in the literature, estimates were chosen to bias the model in favor of the traditional management strategy. **RESULTS:** The average cost per patient was $1045 and $1172 for the traditional “step-up” and PPI test strategies, respectively. The percentage of patients symptom-free at 1 year was 50% and 75% for the traditional and PPI test strategies, respectively. The incremental cost-effectiveness ratio for the PPI test strategy was $510 per additional symptomatic cure. The traditional strategy resulted in a greater than 5-fold increase in endoscopy utilization but a 47% reduction in the use of PPIs by 42%–57%. The PPI test strategy remained most cost-effective as long as the sensitivity of the PPI test was greater than 23% and more than 47% of patients with a positive PPI test received a “step-up” strategy with sequential invasive diagnostic testing as needed. The reduced effectiveness of the traditional strategy may be attributed to a 18% increase in the use of high-dose H2RAs while reducing the use of PPIs by 42%–57%. The PPI test strategy remained most cost-effective as long as the sensitivity of the PPI test was greater than 23% and more than 47% of patients with a positive PPI test received a “step-down” trial. **CONCLUSIONS:** Strategies utilizing the initial PPI test followed by a “step-down” approach may result in improved symptom relief over 1 year, and more appropriate utilization of invasive diagnostic testing at a small marginal cost increase. These findings warrant a prospective trial comparing these strategies.

**ECONOMIC IMPLICATIONS FOR SAFETY-NET HOSPITALS: SCREENING FOR HEPATITIS C**

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Recent work has shown that screening for Hepatitis C is cost-effective from a societal perspective. Safety-net hospitals are committed to providing care for their many uninsured and underinsured patients who are unable to pay. Adopting a screening policy would commit the institution to pay for expensive treatment for many of the screened positives. **OBJECTIVE:** Examine the economic implications for a safety-net hospital that adopts a Hepatitis C screening policy. **METHODS:** A Markov decision analytic model was constructed, using a reference case of a 35-year-old male without symptoms of Hepatitis C. The perspective adopted was a safety-net hospital. Two populations were examined: uninsured, and insured, but without coverage for combination interferon+ribavirin. Screening consisted of ELISA followed by a confirmatory PCR. It was assumed that PCR and virus genotyping were sent to an outside laboratory. Data came from prior publications. Patients were considered to be patients of this facility for 5 years. **RESULTS:** In the uninsured group, screening costs an additional $245 per patient, with an incremental cost-effectiveness ratio (ICER) of $12,300/QALY. As prevalence of infection ranged from 0.8%–9%, the additional cost of screening ranged from $77–$587, and the ICER from $11,500/QALY–$16,800/QALY. In the underinsured group, screening was associated with an additional cost of $166 per patient, with an ICER of $8300/QALY. Varying the prevalence produced additional costs of $38–$427. **CONCLUSIONS:** Although ICERs would appear to be cost-effective from a societal perspective, this is less clear for hospitals that deal with hard budgets, not the soft budget, cost-conscious environment assumed by incremental cost-effectiveness analysis. Screening for Hepatitis C may be an expensive policy to implement for safety-net hospitals. Public funding to support a screening and treatment program may be well justified.