Conclusion: CAM therapy was prevalent among our ACS patients with most using CAM for symptom management and learning about it from their family and friends, with an average out of pocket cost of $92 a month. Given the high prevalence of use and cost, it is essential that medical science investigate the efficacy and potential risks of CAM in patients with coronary artery disease.

POSTER SESSION
1215 Quality of Care for Heart Failure Tuesday, March 19, 2002, 3:00 p.m.-5:00 p.m.
Georgia World Congress Center, Hall G Presentation Hour: 4:00 p.m.-5:00 p.m.

1215-163 Underprescribing Angiotensin Converting Enzyme Inhibitors in Heart Failure: A Missed Economic Opportunity

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Background: Despite demonstrated benefits and recommendations by national guidelines, angiotensin converting-enzyme inhibitors (ACE-I) are underprescribed in left-ventricular systolic dysfunction (LVSD) and heart failure (HF). The impact of underutilization has not been quantified in the United States. Our objective was to estimate the annual clinical and economic impact of ACE-I underprescribing in patients identified as ideal candidates for, but not receiving, ACE-I, and the cost effectiveness of prescribing ACE-I in these patients.

Methods: The number of potential candidates not receiving ACE-I was determined from the literature. This population was categorized into 3 cohorts corresponding to the populations from large prospective studies: symptomatic chronic systolic HF (SOLVD-Type), post-myocardial infarction (MI) HF (AIRE-Type), and post-MI, asymptomatic LVSD (SAVE-Type). Based on the literature, we estimated the economic burden of underprescribing ACE-I in terms of excess hospitalizations, direct medical costs (inpatient and ACE-I drug costs), deaths, and life-years lost.

Results: We estimate that more than 280,000 ideal candidates for ACE-I fail to receive treatment, of which 187,850 are SOLVD-Type, 60,771 AIRE-Type, and 32,566 SAVE-Type. ACE-I use in these patients could potentially prevent 2,217,2,466, and 436 premature deaths, respectively, and save $4,787, 5,469 and 980 years of life annually, respectively. Symptomatic, post-MI, 12,845, 3,403, and 235 hospital stays could be averted annually, avoiding $128,5 mil, $34 mil, and $2.4 mil in hospital costs, respectively. Upon inclusion of drug cost ($390 per patient per year), ACE-I treatment in these populations was projected to result in net cost savings of $83 mil (SOLVD-Type) and $10 mil (AIRE-Type) and in a net cost of $10 mil (SAVE-Type) annually. Thus, treating patients in the first two groups was projected to cost $10,800 per life-year saved.

Conclusion: Treating the estimated 280,000 patients with LVSD or HF who could benefit from ACE-I therapy is an economically attractive investment to improve quality of care.

1215-169 Physician Specialty and Quality of Care for Elderly Patients Hospitalized With Heart Failure

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Background: Whether specialist care is associated with better quality of care remains controversial. We sought to determine whether attending physician specialty is associated with quality of care among elderly patients hospitalized with heart failure. Patients hospitalized at for-profit hospitals (OR 1.27, 95% CI 1.16-1.51 vs public) were more likely to have a cardiologist as their attending. Conclusions: Cardiologists were attending for only one fourth of older patients hospitalized with HF. These patients are younger with less comorbidity than patients cared for by either internists or family practitioners. Case mix should be considered when making quality of care and outcomes comparisons between specialties.

1215-170 Impact of Age, Gender, and Race on Quality of Care of Elderly Patients With Congestive Heart Failure


Background: Congestive heart failure (CHF) is more common in the elderly, females, and non-whites in the United States. However, the influence of age, gender, and race on the quality of care of CHF patients (pts) has not been extensively studied.

Methods: We evaluated Medicare beneficiaries admitted to acute care hospitals in Southeast Michigan with CHF (1/1/98-12/31/98). Patients were identified retrospectively using ICD-9 codes for CHF. They were divided into 3 age groups: Group A (65-74 years), Group B (75-84 years) and Group C (85 years). Quality indicators (in ideal population) were evaluated among different race and gender strata.

Results: The quality care indicators and the impact of age, gender, and race are shown. (Table). There were no differences in the length of stay for the different age groups, gender, or race. One year mortality was higher in whites compared to non-whites (36.6% vs. 33.9%, p<0.05) with a trend towards higher 1-year mortality with increasing age. Gender did not influence 1-year mortality.

Conclusion: Quality of care is adversely affected by increasing age and female gender in hospitalized CHF pts. This data identifies a significant opportunity for improvement in the quality of care in these high risk subgroups that needs to be addressed.

Quality Group A Group B Group C Male Female White Non-P- value p=0.001
Discharge ACE-Inhibitor/ARB (%) 80.4 77.6 75.2 0.429 78.1 78.7 0.804 78.0 94.4 0.001
LVEF documented (%) 70.3 69.4 62.1 0.001 70.1 66.5 0.004 68 67.8 0.88
Discharge smoking cessation counselling (%) 33 20 10.5 0.10 30.6 22.3 0.157 30.2 22.8 0.21
Discharge written instructions (%) 96.1 97.2 94.9 0.122 96.5 0.787 0.142 96.8 97.8 0.265
Weights measured, >/=50% hospital days (%) 67.3 67.9 55.3 0.003 68.6 0.63 0.015 69.3 64.8 0.566
Discharge warfarin in CHF pts with atrial fibrillation (%) 56.4 44.6 28.4 0.002 47.2 44.4 0.575 46.9 42.4 0.486

Weights measured, >/=50% hospital days (%) 67.3 67.9 55.3 0.003 68.6 0.63 0.015 69.3 64.8 0.566
Discharge warfarin in CHF pts with atrial fibrillation (%) 56.4 44.6 28.4 0.002 47.2 44.4 0.575 46.9 42.4 0.486

ACE-I at Discharge 80.8 78.1 76.8 0.37
Discharge Counseling 50.8 45.7 <0.01
Discharge Counseling Smoking Cessation 25.6 24.1 0.11
Medications 66.6 63.9 0.13
Weight Monitoring 10.6 8.2 8.2 <0.01
Follow-up Appointment 92.3 89.8 90.7 <0.01
Worsening Symptoms 23.5 21.6 20.1 0.03