only small variation of the excessive cost distribution can be explained by quality.

PCV105

IMPACT OF GUIDELINES FOR TREATMENT AND PROPHYLAXIS OF VENOUS THROMBOEMBOLISM IN COMMUNITY HOSPITALS

Vats V1, Nutescu EE1, Theobald JC2, Wojynke JJ1, Schumock GT1

1University of Illinois at Chicago, Chicago, IL, USA, 2HealthTrust Purchasing Group, Brentwood, TN, USA.

OBJECTIVE: To evaluate the impact of guidelines for treatment and prophylaxis of VTE on appropriateness of anticoagulant therapy, JCAHO performance measures, adverse drug outcomes, and total cost of therapy. METHODS: We conducted a multi-hospital "pre-post" guideline intervention study. Guidelines for VTE treatment and prophylaxis were developed and implemented in the participating hospitals. Retrospective chart review was used to collect patient data during the pre and post periods. RESULTS: The number of participating hospitals and total patient cases submitted by the hospitals were 23 and 617, respectively in the pre-guideline (PRG) phase and 13 and 338, respectively in the post-guideline phase (POG). The appropriateness of prescribing (as measured by the dose, duration, and the type of anticoagulant used) increased by 7% (PRG 77%, POG 84%). JCAHO performance measures for 1) percentage of VTE patients receiving education; 2) percentage of patients with reduced LMWH dosage in compromised renal failure; 3) percentage of patients with normal INR; 4) percentage of patients with objective confirmation of clinically suspected VTE; 5) percentage of unfractionated heparin (UFH) managed by nomogram/protocol; and 6) percentage of patients with anticoagulation overlap of parenteral and warfarin therapy, increased by 20%, 17%, 13%, 9%, 6%, and 1%, respectively. JCAHO measures for 1) VTE treatment for discharged patients with active cancer, and 2) platelet count monitoring for patients with VTE receiving UFH, decreased by 2% and 11%, respectively. The proportion of patients experiencing at least one anticoagulant related adverse drug outcome decreased by 0.5% and rates of major bleeding decreased by 1% in POG. On average, the total cost of therapy (cost of major/minor bleeding, DVT, PE and drugs costs) decreased by $105 per patient in POG.

CONCLUSION: Implementation of VTE treatment and prophylaxis guidelines improved appropriateness of anticoagulant therapy in the participating hospitals resulting in improved outcomes, reduced costs, and improved quality performance.

DIABETES/ENDOCRINE DISORDERS—Clinical Outcomes Studies

PDB1

EXENATIDE UTILIZATION AND EFFECTIVENESS IN A HEALTH PLAN POPULATION

Schroeder B1, Misurski D1, Wade R1, Quimbo R2, Nielsen L1, Faburni R1, Windle M1

1Amylin Pharmaceuticals, Inc, San Diego, CA, USA; 2Eli Lilly and Company, Indianapolis, IN, USA.

OBJECTIVE: Numerous clinical outcomes trials have demonstrated the benefits of achieving glycemic goals in patients with type 2 diabetes (T2D). In controlled clinical trials, the incretin mimetic exenatide improved glycemic control in patients with T2D; 34% to 46% of patients achieved A1C ≤7% and mean A1C change from baseline was −0.8% to −0.9% (baseline A1C 8.2% to 8.7%). To investigate the effects of exenatide in clinical practice, this retrospective cohort study used a large, US commercial health plan claims database to describe baseline characteristics, comorbidities, concomitant therapies, and clinical effectiveness in patients initiated on exenatide. METHODS: A total of 4936 patients were identified having a new prescription claim for exenatide between May 1, 2005 and June 30, 2006 (first claim = index date), with ≥12 months of pre- and post-index eligibility, and ≥18 years old. RESULTS: Mean (±SD) age was 53.7 ± 10.2 years (11.7% ≥65 y; 52% female). The 12-month mean (SE) medication possession ratio (MPR = days of supply/365 days) in patients with >1 prescription claim was 66% ± 30%. Most patients analyzed (94%) were treated with at least one other antidiabetic medication at initiation (100 d pre-index to 15 d post-index); 25% with one drug, 35% with two drugs, and 34% with ≥3 drugs. The mean number of antidiabetic drugs (including exenatide) per patient was similar at initiation (3.08) and post-index (3.05). Clinical effectiveness was measured in all patients with an A1C ≥7.0% at baseline (≤100 d pre-index) and having both baseline and post-index (60–365 d) A1C data available (n = 201; mean baseline A1C = 8.9 ± 1.5%). In this cohort, 31% achieved A1C ≤7% in the post-index period and mean A1C change from baseline was −0.8%. CONCLUSION: The mean change in A1C and percentage of patients achieving A1C ≤7% in this real-world analysis mirrored results of controlled clinical trials. Furthermore, glycemic improvement was achieved without a further increase in concomitant antidiabetic drugs.

WITHDRAWN