GI DISEASES/DISORDERS

GI DISEASES/DISORDERS—Health Policy Studies

PGI11 RETROSPECTIVE ANALYSIS OF A PRIOR AUTHORIZATION PROGRAM USING COX-2 INHIBITORS IN A MANAGED CARE POPULATION

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OBJECTIVES: This study examines the patient level factors that play role in initiating the process of prior authorization, and evaluates whether prior authorization (PA) process has an effect on future gastrointestinal (GI) outcomes (e.g. bleeding, peptic ulcer disease (PUD)) in managed care population. METHODS: Patients who encountered a PA system edit for Cox-2 inhibitors during January 1, 2001 to July 31, 2002 were followed up for 1 year post rejection date. Patients were stratified to 2 groups; 1) initiated the process of PA, 2) never initiated the process of PA. Using multivariate logistic regression, significant covariates in predicting future GI bleed or PUD, and applying for PA were identified. Charlson Comorbidity Index (CCI) was calculated for each patient and used in the regression analysis. RESULTS: Those who initiated the PA process were significantly older, had higher CCI, higher total medical and pharmacy costs, and more GI events than those who never applied for a PA. Significant covariates in predicting future GI bleed were aged £65, previous GI bleed or PUD, and higher CCI. In addition to gender similar covariates also predicted future PUD where females were at higher risk of having a PUD. Whether prior authorization process was initiated or not was not a significant factor in predicting future GI event. Patients who were females or age £65, with osteoarthritis, rheumatoid arthritis, previous ulcer or GI bleed event, or high CCI score were more likely to apply for PA. CONCLUSION: PA process appears to select high risk patients to receive Cox-2 inhibitors. Patients who did not apply for PA appear to have similar adjusted future GI event rate than those who applied.

GI DISEASES/DISORDERS

GI DISEASES/DISORDERS—Methods

PGI12 EVALUATING THE GERD SYMPTOM AND MEDICATION QUESTIONNAIRE (GERD-SMQ) IN A CLINICAL TRIAL

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OBJECTIVES: Assess the construct validity of the GERD-SMQ in relation to esophagitis grade severity, symptom severity, and quality of life within a clinical trial. METHODS: The GERD-SMQ was administered to 1722 subjects participating in a multicenter, randomized double-blind clinical trial. Subjects had a history of erosive esophagitis based on an endoscopy (EGD) performed at study entry or a previous EGD within five years. The Modified Hetzel-Dent Grading Scale was used to determine esophagitis grade scores. A 4-point Likert scale was used to assess GERD symptoms and the Gastroesophageal Reflux Disease Symptom Assessment Scale (GSAS) distress domain assessed quality of life (QOL). Logistic regression, using the GERD-SMQ score (based on previous validation using the heartburn + regurgitation + medication subscores) as the independent variable, was performed to test the GERD-SMQ’s degree of association with esophagitis grade and GERD symptoms. ANOVA techniques, using QOL as the independent variable, were employed to test the GERD-SMQ’s degree of association with QOL scores. RESULTS: Results of ordinal logistic regression univariate analyses using esophagitis grade score as the dependent variable showed that as GERD-SMQ score increased by one unit, the odds of having more severe symptoms also increased significantly (OR 1.04, p < 0.05). Using screening symptoms scores as the dependent variable, the odds of having more severe symptoms significantly increased with observed increases in GERD-SMQ scores (OR 1.22, p < 0.0001). Analysis of variance results showed that for every one unit increase in the GSAS distress score, the GERD-SMQ score significantly increased by a factor of 2.39 (p < 0.0001). CONCLUSIONS: Significant relationships exist between the GERD-SMQ score, specific symptoms and clinical severity markers demonstrating that the GERD-SMQ is valuable in the clinical trial setting. Further evaluation of the GERD-SMQ is warranted to determine the use of this questionnaire in patients with symptoms of GERD with or without erosive esophagitis.

INFECTIONS

INFECTIONS—Clinical Outcomes Studies

PIN1 OUTCOMES OF AN INTERACTIVE VOICE RESPONSE (IVR) REMINDER SYSTEM TO PROMOTE MANAGED CARE ORGANIZATION (MCO) MEMBERS’ ATTAINMENT OF INFLUENZA IMMUNIZATION

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OBJECTIVES: To determine if an IVR intervention was associated with attainment of the preventive service of influenza immunization for older adults. METHODS: A MCO in the Eastern U.S. identified a cohort of members (n = 22,501) age 65 and over as of January 1st, 2002 who were eligible for influenza immunization based on the Health Plan Employer Data and Information Set (HEDIS) specifications. The intervention consisted of telephone calls with IVR system prompts to remind patients to get immunized. Rates of adherence were compared based on whether members received a reminder. Calls were classified as reminders if the targeted member was contacted directly, or called in to the system after having heard the reminder, or if the reminder was left with another household member or on an answering machine. Calls were classified as non-reminders if the member hung-up, no connection was made, or if the targeted member or another household member declined the intervention. The telephone intervention began October 10th, 2002 and ended January 21st, 2003. Claims data for immunizations were evaluated from October 10th, 2002 to March 31st, 2003. Multivariate logistic regressions evaluated associations between the intervention and odds of getting the influenza immunization, controlling for age group and gender. RESULTS: Of members receiving the IVR reminder 6.9% got influenza immunizations, while 3.2% of members not receiving the reminder got immunizations (p < 0.0001). Logistic regression revealed significant associations between the IVR reminder and the likelihood of receiving the immunization, controlling for age group and gender (p < 0.0001). Neither age group nor gender significantly affected the odds of getting an immunization. Members who received a
reminder were 2.15 times (95% CI = 1.73 to 2.61) more likely to have an influenza immunization. CONCLUSIONS: Although influenza immunization rates remain low, IVR reminders produce higher rates of influenza immunizations and increase patient adherence in older adults.

**PIN2**

**RETREATMENT RATES OF ACUTE OTITIS MEDIA IN PATIENTS WITH TYMPANOSTOMY TUBES WITHIN THE LOUISIANA MEDICAID PROGRAM**

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OBJECTIVES: Retreatment of acute infections can often be high thereby increasing treatment costs. This study examined the retreatment rates of acute otitis media in patients with tympanostomy tubes (AOMT) within the Louisiana Medicaid population. METHODS: Louisiana Medicaid claims data for 2000–2002 were retrospectively reviewed for episodes of AOMT. Tympanostomy tube (t-tube) patients were identified using CPT codes from an index period of January 1, 2000 through June 30, 2000. AOMT patients were followed for 24 months from their respective index dates. Episodes of AOMT were then identified from the t-tube sample group using ICD-9-CM codes. An episode started with the first antibiotic claim between one day before or two days after an ICD-9-CM code for AOMT and ended 21 days later. Retreatment was defined as the presence of another antibiotic claim between days 3 and days 21 of an episode of care. Only antibiotics commonly used in the treatment of AOMT were considered in the retreatment analysis. Retreatment rates were calculated on an overall (per episode) basis and by antibiotic. RESULTS: There were 5934 episodes of AOMT care identified within the dataset of which 1381 required retreatment resulting in an overall retreatment rate of approximately 23%. Some of the antibiotics commonly prescribed in the treatment of AOMT are presented in rank order relative to their retreatment rates: ciprofloxacin HCL and hydrocortisone (12%), cephalexin (17%), ofloxacin (26%), amoxicillin (28%), amoxicillin potassium clavulanate (32%), sulfamethoxazole trimethoprim (32%), azithromycin (32%), clarithromycin (33%), cefdinir (33%), and cefprozil (36%). CONCLUSIONS: The retreatment rate of AOMT in the Louisiana Medicaid population was high with approximately 1 out of 4 episodes requiring retreatment. Retreatment rates also varied considerably between antibiotic therapies. Careful consideration of AOMT antibiotic therapy by clinicians may reduce retreatment rates thereby lowering the associated cost of AOMT treatment in the Louisiana Medicaid program.

**PIN3**

**OUTCOMES FOLLOWING THE USE OF AZITHROMYCIN OR CLARITHROMYCIN FOR RESPIRATORY TRACT INFECTIONS IN A MEDICAID POPULATION**

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OBJECTIVE: To better understand the consequences of branded macrolide therapy, we assessed rates of re-treatment following the use of azithromycin or clarithromycin among outpatients diagnosed with common respiratory-tract infections in the California Medicaid (“Medi-Cal”) program. METHODS: We employed a retrospective cohort design using administrative claims data for a 20% random sample of California Medicaid recipients. We selected outpatients diagnosed with common upper or lower respiratory-tract infections, including acute otitis media, acute pharyngitis, acute sinusitis, chronic bronchitis, or community-acquired pneumonia during an office visit between February 1, 1997 and May 31, 2002. Patients were prescribed either azithromycin or clarithromycin as treatment following diagnosis. The main study outcome was the filling of another prescription for an antibiotic (i.e., “retreatment”) within 30 days following receipt of branded macrolide therapy. For each infection type, logistic regression was used to estimate the rate of retreatment for the two initial macrolides, adjusting for age. RESULTS: We identified 6196 patients diagnosed with acute otitis media, 3794 with community-acquired pneumonia, 2716 diagnosed with pharyngitis, 1354 with chronic bronchitis, and 1162 with sinusitis who received one of the two macrolides of interest. Sixteen (acute otitis media) to 20% (sinusitis) of patients failed treatment with their initial macrolide. Relative to clarithromycin, azithromycin was associated with a significantly lower retreatment rate when used in patients with acute otitis media (OR: 0.63; 95% CI: 0.50 to 0.80; P < 0.0001) or chronic bronchitis (0.70; 0.50 to 0.98; P = 0.039). The likelihood of retreatment (azithromycin relative to clarithromycin) did not differ for patients with pharyngitis (0.96; 0.74 to 1.26; P = 0.783), sinusitis (1.03; 0.75 to 1.42; P = 0.842), or community-acquired pneumonia (0.93; 0.77 to 1.13; P = 0.450). CONCLUSIONS: Compared to clarithromycin, azithromycin is associated with a lower retreatment rate when used for acute otitis media or chronic bronchitis in this Medicaid population.

**PIN4**

**EXAMINATION OF HEPATITIS C IN THE LOUISIANA MEDICAID POPULATION**

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OBJECTIVE: The purpose of this study was to examine the epidemiology of Hepatitis C (HCV) in the Louisiana Medicaid population. HCV is estimated to have infected 170 million people worldwide. In many countries, it is the most common cause of chronic liver disease and is the most common indication for liver transplantation. Progression and complications of the disease may lead to cirrhosis, liver failure, and hepatocellular carcinoma (HCC). HCV affects nearly 4 million people in the U.S. HCV causes an estimated 10,000 to 12,000 deaths annually in the U.S. Approximately 70% of these people develop chronic hepatitis and 20% progress to cirrhosis predisposing them to HCC. METHODS: This study is a retrospective secondary database claims analysis. Medicaid recipients were followed longitudinally for the years 1998, 1999, and 2000, which consequently constitute the study period for this research. Recipients were included in one of two groups based on their diagnosis: Infected (having HCV) and at-risk (having a diagnosis of hemophilia, cocaine addiction, drug abuse, cirrhosis, hepatitis B, and HIV or received hemodialysis). Only recipients who were continuously eligible throughout the 3-year study period were included in the study. RESULTS: The prevalence of HCV in the LA Medicaid population during the study period was 7.08 per 1000. Among the at-risk population, the recipients with a diagnosis hemophilia or drug abuse had the highest prevalence. There were 18,286 recipients in the at-risk group while 2128 recipients were classified in the infected group. The infected group consisted of 1151 females (54%) and racial breakdown showed that 1183 (55%) African Americans had HCV. Similar results were obtained when at-risk groups were analyzed. CONCLUSIONS: Most frequently occurring comorbidities in the infected population, were asthma, chest pain, urinary tract infection and bronchitis. About 30% of the recipients in the at-risk group had been tested for HCV.