SWITCHING, AUGMENTATION AND TITRATION OF LIPID LOWERING AGENTS OF MEDICARE/MEDICAID DUAL ELIGIBLE PATIENTS BY ETHNICITY
Mucha L1, Mark T2, Axelsen K3
1Thomson Medstat, Cambridge, MA, USA, 2Thomson, Washington, DC, USA, 3Pfizer Global Pharmaceuticals, New York, NY, USA

OBJECTIVES: The objective of this study was to examine prescribing patterns of lipid lowering agents among Medicare/Medicaid dual eligible patients by ethnicity. METHODS: Data came from the Thomson Medstat Marketscan® Medicare and Medicaid claims databases. Beneficiaries who were prescribed these agents during 2003 and enrolled for the full year in both databases were in the study sample. Logistic regression models estimated the probability of a switch, augmentation, or titration up, by ethnicity. Switching was a change in the agent, augmentation was at least 30 days of overlapping therapy, and titration upwards was an increase in dosage for two consecutive prescriptions. RESULTS: There were 239,530 patients included in the study. Fewer African Americans (9%) switched lipid lowering agents than Asians, Hispanics, Caucasians or other ethnicities (14%, 13%, 12%, and 13%, respectively) did. Fewer African Americans (3%) augmented with another agent than Asians, Hispanics, Caucasians or others (6%, 5%, 6% and 5%). Logistic regressions showed that African Americans were significantly less likely to switch (OR 0.68; 95% CI 0.60–0.78), augment (OR 0.53; 95% CI 0.43–0.66), or titrate up (OR 0.75; 95% CI 0.67–0.84) than Caucasians, controlling for age, gender, state of residence, days on therapy, number of outpatient visits, and the Chronic Disease Score. CONCLUSIONS: Results were consistent with the literature which shows lipid lowering agent prescribing for African Americans tended to be less aggressive, as evidenced by fewer switches, less augmentation and less upward titration. This may reflect treatment differentials such as clinicians being less likely to increase doses of lipid lowering agents to help these patients reach goal. It may also reflect the effectiveness of these agents in lowering lipid levels and keeping patients at consistently low levels. These treatment issues merit further observation as dual eligibles move into Medicare part D plans with differing coverage and formulary restrictions.

MANAGING CONGESTIVE HEART FAILURE: COHORT ANALYSIS OF USE AND COST OF HOSPITAL, EMERGENCY DEPARTMENT AND OBSERVATION UNIT CARE OVER TWELVE MONTHS
O’Brien JA1, Duran PA, Pitioniak-Morse C, Caro JJ
Caro Research Institute, Concord, MA, USA

OBJECTIVES: Examine use and cost of inpatient, emergency department (ED), and observation unit (OU) services during one year by patients treated for congestive heart failure (CHF). METHODS: Using 2001–2002 Massachusetts hospital, ED and OU data, a cohort of adult patients (age: 18+ years) with CHF (ICD-9 principal diagnosis code: 428.0–428.9) was identified. A patient CHF encounter profile was established starting with the first stay/visit (index encounter) at any hospital, ED or OU in 2001 and included all subsequent inpatient, ED or OU care for CHF within 12 months. Charges (accommodations, ancillary services) adjusted by a 0.55 cost-to-charge ratio, medical inflation and geographic factors are reported as 2005 US$ costs. RESULTS: The patient cohort (n: 18,550; females: 56%; mean age: 61 years, range: 18–104) used a combined total of 28,673 CHF-related hospitalizations, ED and OU stays during one year (mean encounters: 1.5, range: 1–29). Of all encounters, 84% were inpatient, 12% ED and 4% OU. Only inpatient care was used by 79% of the cohort (mean stays: 1.4, range: 1–16); 8% ED only (mean visits: 1.1, range: 1–19); 3% OU only (mean stays: 1.1, range: 1–3); 9% used multiple care settings (mean encounters: 3, range: 2–12); and 1% used all (mean encounters: 5.2, range: 3–29). Patients with inpatient plus ED or OU care had a significantly (p < 0.01) greater readmission rate (44%) for CHF than those utilizing only inpatient care (26%). On average, hospital length of stay was 5.4 days, cost: $7736; ED visit: 4.7 hours, cost: $740; OU stay: 29 hours, cost: $2468, per encounter. Cumulative cost for hospital, ED and OU care for one year was roughly $190 million. CONCLUSIONS: Inpatient care was the dominant non-routine setting for acute management of CHF. Those utilizing multiple acute care locations are more likely to have multiple hospitalizations within one year.