patterns were assessed at 6 months following hospital discharge for patients who received only BMS and for patients with at least 1 DES. METHODS: A prospective, observational registry of 11 European countries grouped into 6 clusters recruited acute coronary syndrome patients undergoing PCI from 2008–2009. Interventional cardiologists collected data from ACS events up to hospital discharge, and primary care physicians and cardiologists collected 6-month data. RESULTS: Of 3042 eligible patients at baseline, 2964 (97%) had 6-month data, of which 2842 (96%) received a stent at index PCI. The percentage of patients with at least 1 DES was 17% in the Czech Republic, 31% in Greece, 33% in Austria–Hungary, 32% in Belgium–The Netherlands, 37% in the Nordic countries, and 81% in Greece. The percentage of patients taking dual antiplatelet therapy at hospital discharge ranged from 93% in Belgium–The Netherlands to 100% in Greece for BMS only and from 93% in Belgium–The Netherlands to 100% in Czech Republic for patients with DES. Aspirin use ranged from 89% to 100% across the countries and type of stent. CONCLUSIONS: Use of DES versus BMS varied among the European countries. In patients with BMS, there was marked variability with clopidogrel use at 6 months; whereas, in patients with DES, clopidogrel was used more frequently and with less variability.

AN INTERNATIONAL COMPARISON OF ANTIPLATELET USE AT 6 MONTHS FOLLOWING HOSPITAL DISCHARGE IN UA/NSTEMI AND STEMI PATIENTS UNDERGOING PCI: RESULTS FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL REGISTRY II (APTOR-II)

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OBJECTIVES: Current European Society of Cardiology Guidelines recommend dual antiplatelet therapy for 12 months for all patients with acute coronary syndrome (ACS). The variations in antiplatelet treatment patterns at 6 months following hospital discharge were assessed in patients with unstable angina (UA), non-ST-elevation myocardial infarction (NSTEMI), and ST-elevation MI (STEMI) undergoing percutaneous intervention (PCI). METHODS: A prospective, observational registry of 11 European countries grouped into 6 clusters recruited acute coronary syndrome (ACS) patients undergoing PCI from 2008–2009. Interventional cardiologists collected data from ACS events up to hospital discharge, and primary care physicians and cardiologists collected 6-month data. RESULTS: Of 3042 eligible patients at baseline, 2964 patients (97%) had 6-month data; 51% of patients presented with STEMI and 49% with UA/NSTEMI. The median age was 62 years. At 6 months following hospital discharge, the percentage of UA/NSTEMI and STEMI patients using clopidogrel, respectively, was 70% and 40% in the Czech Republic, 84% and 99% in Greece, 98% and 99% in Greece, 78% and 81% in the Nordic countries, 93% and 94% in Austria and Hungary, and 81% and 88% in Belgium and the The Netherlands. The percentage of UA/NSTEMI and STEMI patients taking aspirin, respectively, was 98% and 99% in the Czech Republic, 89% and 91% in Germany, 97% and 100% in Greece, 95% and 93% in the Nordic countries, 94% and 96% in Austria and Hungary, and 91% and 94% in Belgium and the The Netherlands. CONCLUSIONS: Use of clopidogrel varied considerably between European countries at 6 months after discharge, whereas the aspirin (99%) of patients continued to use aspirin. Results suggest that both physician and patient education on continuing dual antiplatelet therapy may be needed.

PRACTICE PATTERNS AND QUALITY OF LIFE IN ACUTE CORONARY SYNDROME PATIENTS IN 2008–2009: BASELINE RESULTS FOR GERMANY FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL REGISTRY II (APTOR-II)

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OBJECTIVES: This analysis aims to explore management of acute coronary syndromes (ACS) from acute event to hospital discharge in Germany, and to measure Quality of Life (Qol) at discharge. METHODS: This 12-month international prospective, observational study recruited ACS patients undergoing percutaneous coronary intervention (PCI), April 2008–March 2009, capturing practice patterns, resource use and outcomes. RESULTS: 908 ACS-PCI patients (out of the 508 recruited) were eligible. The median age was 63 yrs (IQR 53–72), median weight 82 kg (IQR 74–92), 23% female, 24% Type I diabetes, and 27% prior myocardial infarction (MI). Index diagnosis was: unstable angina or non-ST-elevation MI (UA/NSTEMI)-53% and ST-elevation MI (STEMI)-47%. Almost all patients (96%) were on aspirin, 64% on beta blockers, 32% on statins, 68% on calcium channel blockers (CCB), and 86% on other antianginals. CONCLUSIONS: The mean modified quality of life score was 0.5. Of 1643 patients surveyed, 57.88% were in the lowest-risk group (0–1 risk factors); 14.36% were in the highest-risk group (CHD or CHD-risk equivalent). For the 1681 women, these percentages were 73.11% and 13.30%, respectively. Of people needing a stent, 73.74% needed LDL-C lowering by <25%; only 1.16% required LDL-C lowering of >60%. Therapeutic market shares were estimated at 20.11% (rosuvastatin); 18.94% (atorvastatin); 17.89% (simvastatin); 16.96% (lovastatin); 13.05% (fluvastatin); and 13.05% (pravastatin). CONCLUSIONS: Actual market share varied considerably from market shares based on lipid-lowering considerations. Explanations include direct-to-consumer advertising; varying pricing strategies; and clinical trials for additional indications and subpopulations conducted only by the market leaders.

CREATING AN EFFICIENT HOSPITAL PAYMENT SYSTEM

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OBJECTIVES: By creating incentives around quality and efficiency, there exists consideration to bundle hospital and physician payments around the episodes of inpatient surgery. We provided current payments around surgical episodes including the degree of payment type (hospital, physician, and post-acute care) and sub-type. METHODS: The study was based on complete national U.S. claims data. Managed care patients were excluded in 2005 from the study because only beneficiaries who were consistently captured in the data set. We also excluded patients who were less than 65 years of age or over 99, and those not enrolled in the data set at the time of their procedures (4%). Also excluded were patients who were nursing home residents before surgery. Patients undergoing CABG were identified using ICD-9 codes. Price-standardized payments from the date of admission for the index procedure to 30 days post-discharge were determined and categorized by payment type (hospital, physician, and post-acute care) and sub-type. RESULTS: The average total payment around an inpatient surgery episode was $45,358 for CABG. Hospital payments accounted for the largest of total payments (66% of the procedure), followed by physician payments (13%), Diagnosis-Related Group (DRG) payments and surgeon and anesthesia professional payments together accounted for 6% of total payments. Among payment types potentially leveraged by bundled payments, 30-day readmissions accounted for 10% of total payments around surgical episodes. Post-acute care, including home health care and extended care facilities, accounted for 7% of total payments. CONCLUSIONS: Payments for potentially mutable services, including outlier payments, 30 day readmissions, and post-acute care are considerable and might be reduced by incentives for hospitals and physicians to improve quality and efficiency.

ATRIAL FIBRILLATION MANAGEMENT PATTERNS IN GREECE

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OBJECTIVES: Construct the disease management model for patients with Atrial Fibrillation (AF) in Greece, according to initial therapeutic approach. METHODS: The analysis was based on data from patient records of 149 geographically distributed cardiologists, extracted via strictly structured questionnaire-based interviews. Participi-