INDIVIDUAL’S HEALTH – Clinical Outcomes Studies

ASSESSMENT OF LENGTH OF STAY FOR WOMEN WITH HIGH RISK CO-MORBIDITIES DURING LABOR AND DELIVERY

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OBJECTIVES: Chronic co-morbid conditions during pregnancy have been associated with poor maternal and infant health. Although studies have shown that women with anemia, diabetes or thyroid dysfunction during pregnancy are at high risk of complications in delivery, little is known about their impact on the length of hospitalization. The objective of this study was to identify the increased Length of Stay (LOS) of pregnant women with these high-risk comorbidities compared with other comorbidities, hospitalized for delivery and labor in the US. METHODS: The 2006 National Hospital Discharge Survey (NHDS) was used as data source for the study. ICD-9-CM codes were retrieved to extract records of women with comorbid complications during labor and delivery (660.0-669.9) and to further identify women with high-risk comorbidity of anemia (648.0), diabetes (648.2) or thyroid dysfunction (648.1) complicating pregnancy, childbirth, and the puerperium. Survival analysis along with log rank test was used to evaluate the differences of LOS between patients with high risk comorbidities and low risk comorbidities. RESULTS: The 2006 NHDS recorded data for a total of 23,941 women with complications in delivery and labor. Among these, 2,490 women had high risk comorbidities while 21,451 women had other comorbidities complicating their delivery and labor. The median LOS for women with high risk comorbidities (3 days) was 1 day higher compared to pregnant women with other co-morbidities (2 days; p = 0.001). CONCLUSIONS: This study provides empirical data on LOS for women with high risk comorbidities in the course of labor and delivery. This result can be used as a basis by hospitals to assess their precautionary guidelines in pregnant women with high risk comorbidities to avoid additional LOS. Further research can be performed to investigate the impact of demographic characteristics and source of payment on the LOS of pregnant women with high risk comorbidities.

CLINICAL AND COST OUTCOMES AMONG PATIENTS ON WARFARIN WITH ELECTRONIC ALERTS TO REMIND PROVIDERS ABOUT HIGH INTERNATIONAL NORMALIZED RATIO

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OBJECTIVES: To understand benefits and risks of backing out of an alert for warfarin administration when high International Normalized Ratio (INR). Adverse drug reactions are one of the major causes of hospital readmissions. This study was performed to establish if backing out of the alert for patients on warfarin causes clinically significant adverse outcomes and complications 3–4 years. Methods: A national surveillance study of patients with warfarin in a community-based hospital for the period from January 2008 to May 2012. The primary outcome measure was hospitalization for possible assignment to the Beers list. Results: A total of 1087 hospitalizations were reviewed. The rate of an adverse drug reaction was 2.3% (n = 24). The rate of hospitalization was 1.6% (n = 17). Conclusion: This study shows that backing out of the alert for warfarin does not cause adverse outcomes or complications.

PERSONALIZED MEDICINE: TRENDS IN CLINICAL STUDIES BASED ON NATIONAL REGISTRY DATA

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OBJECTIVES: Identified the rate of warfarin related complications (pharmacogenomic) data to guide a treatment decision. Conclusion: This study compared the rate of pharmacogenomic criteria for inclusion or exclusion, or for stratifying (pharmacogenomic) data to guide a treatment decision. We queried ClinicalTrials.gov for studies using pharmacogenomic criteria for inclusion or exclusion, or for stratifying pharmacogenomic data. Over time, the number of trials using pharmacogenomic data has increased greatly and, as expected, most PM trials (15%) were in the therapeutic area of oncology and hematology. However, we observed a marked increase in the number of PM trials for drugs targeting metabolic diseases such as diabetes and cardiovascular disease. This trend is consistent with recent advances in understanding of the molecular basis of disease, with associated implications for assessing relative clinical and cost effectiveness.

AN ANALYSIS OF SELECT INJURY-INCREASING ANALGESIC MEDICATIONS IN MEDICARE DUAL ELIGIBLE ENROLLINES

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OBJECTIVES: To assess the risk of injury-increasing analgesic medications in Medicare dual eligible enrollees. METHODS: We performed an analysis of select injury-increasing analgesic medications in Medicare dual eligible enrollees. We identified beneficiaries with injury-related ER visits between 2006 and 2012 who had at least one ER visit for a condition associated with a high risk of injury-increasing analgesic use. We calculated the rate of injury-related ER visits for each of the select injury-increasing analgesic medications in Medicare dual eligible enrollees. RESULTS: The rate of injury-related ER visits was 10.2% (95% CI: 9.9–10.5) in the Medicare dual eligible enrollees. The rate of injury-related ER visits was significantly higher for patients taking opioids (12.6% (95% CI: 12.3–12.9)) compared to patients not taking opioids (8.9% (95% CI: 8.6–9.2)). The rate of injury-related ER visits was also significantly higher for patients taking opioid analgesics (12.1% (95% CI: 11.7–12.5)) compared to patients not taking opioid analgesics (8.9% (95% CI: 8.6–9.2)). Conclusion: The rate of injury-related ER visits was significantly higher for patients taking opioid analgesics compared to patients not taking opioid analgesics. This finding is consistent with previous research showing that opioid analgesics are associated with an increased risk of injury-related ER visits.