physicians were sent prior to the patient letters. Diabetic patients absent of statin treatment in a prior 120-day period were identified. Continuous eligibility was required for the evaluation and only patients over 17 years of age were included. Patients were observed for adding a statin during a 120-day follow-up period. Controls were identified from four other plans with similar characteristics. One-to-one case-control matching and t-test were performed to evaluate the effect of the interventions. Regression analyses were performed to determine the predictors of intervention responsiveness.

RESULTS: Mean age for patients in the program was approximately 55 years. There were 760 unique patients in both the patient and physician intervention components. Overall, 170 (22.4%) and 112 (11.0%) patients added a statin in the case versus control group (difference 11.4%, p < 0.0001). Specifically, among the physician intervention component there were 17.8% and 11.6% of cases versus controls who added a statin (difference = 6.22%, p < 0.05). Among the patient intervention component there were 12.3% and 8.6% cases versus controls who added a statin (difference 3.84%, p < 0.05). Significant positive predictors of adding a statin include presence of cardiovascular disease, females, and higher comorbidities. CONCLUSION: Educational letter-based programs that are directed to physicians and patients are effective in promoting the use of statin therapy among diabetics.

WITHDRAWN

PCV101

THE ASSESSING CARDIOVASCULAR TARGETS (ACT '07) PROGRAM: PRELIMINARY RESULTS FROM A PRACTICE REFLECTIVE ASSESSMENT ACROSS CANADA

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OBJECTIVE: To examine patients’ level of cardiovascular risk in community based clinical practice and assess whether treatment targets as specified in Canadian clinical guidelines (hypertension—2007, dyslipidemia—2006, diabetes—2003, metabolic syndrome—2006) are met. METHODS: A convenience sample of more than 375 general practitioners recruited from across Canada participated between September and December 2007. Case report forms were completed for at least 20 patients during normally scheduled office visits. Current survey results were compared to a similar survey of 450 general practitioners and 17,188 patients conducted in January to April 2006 that used the 2003 dyslipidemia, 2003 diabetes, & 2005 hypertension guideline targets to assess whether treatment targets were met. RESULTS: A total of 1722 patients analyzed to date of which 98% were taking lipid-lowering drugs. Approximately 14,000 patients’ data will be available upon study completion. Demographics: 57% male, 40% 65 years or older, 53% 45–64 years. CV risk factors identified: 68% hypertension, 38% diabetes, 26% family history premature CAD, 24% previous history of MI, stroke, or PAD, 25% current or recent smoker, 9% evidence of hyperglycemia. Fifty-four percent of cohort had three or more risk factors. Physician assessed CV risk level: 59% high, 24% moderate, 18% low. Forty percent of patients met the criteria for metabolic syndrome. Patients NOT at guideline targets 2007 survey vs. 2006 survey: hypertension 22% vs. 26%, LDL-C 47% vs. 34%, TC : HDL-C 35% vs. 31%, triglycerides 42% vs. 51%, FBG > 6.2 mmol. 34% vs. 44%, waist circumference 55% vs. 55%. CONCLUSION: Preliminary aggregate data shows that despite drug treatment many patients are still not at lipid or blood pressure target levels. Community practice physicians in this survey prescribe lipid-lowering drugs to predominately high (59%) and moderate (24%) CV risk patients.

PCV102

RELATIONSHIP BETWEEN QUALITY OF CARE AND EXCESSIVE COST FOR MEDICARE PATIENTS UNDERGOING LOWER EXTREMITY BYPASS SURGERY

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OBJECTIVE: To examine the relationship between the excessive cost and quality of care across US hospitals for Medicare patients undergoing lower extremity bypass surgery by pass surgery. METHODS: We examined outlier payments in patients undergoing lower extremity bypass surgery (n = 43,886) using National Medicare claims database. Using multiple logistic regression we explored the relationship between hospital outlier payments and hospital quality as reflected by risk-adjusted mortality rates. RESULTS: The proportion of patient associated with outlier payments was 10%. Total Medicare outlier payments for lower-extremity bypass graft was $78,921,669 averaging $18,214 per patient. There was a negative correlation between risk-adjusted mortality rates and outlier payments. Proportion of systematic variation in hospital outlier payment rates explained by hospital factors explained 7.8% of in-between variation of outlier rates in lower extremity bypass. CONCLUSION: There exist negative relationship between quality and excessive cost across the hospitals. However,