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WITHDRAWN PCV101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 hyperglycemia guidelines 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 predominantly high (59%) and moderate (24%) CV risk patients.

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 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,
A218

PCV105

IMPACT OF GUIDELINES FOR TREATMENT AND PROPHYLAXIS OF VENOUS THROMBOEMBOLISM IN COMMUNITY HOSPITALS

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OBJECTIVE: To evaluate the impact of guidelines for treatment and prophylaxis of VTE on appropriateness of anticoagulant therapy, JCAHO performance measures, adverse drug outcomes, and total cost of therapy.

METHODS: We conducted a multi-hospital "pre-post" guideline intervention study. Guidelines for VTE treatment and prophylaxis were developed and implemented in the participating hospitals. Retrospective chart review was used to collect patient data during the pre and post periods.

RESULTS: The number of participating hospitals and total patient cases submitted by the hospitals were 23 and 617, respectively in the pre-guideline (PRG) phase and 13 and 338, respectively in the post-guideline phase (POG). The appropriateness of prescribing (as measured by the dose, duration, and the type of anticoagulant used) increased by 7% (PRG 77%, POG 84%). JCAHO performance measures for 1) percentage of VTE patients receiving education; 2) percentage of patients with reduced LMWH dosage in compromised renal failure; 3) percentage of patients with normal INR; 4) percentage of patients with objective confirmation of clinically suspected VTE; 5) percentage of unfractionated heparin (UFH) managed by nomogram/protocol; and 6) percentage of patients with anticoagulation overlap of parenteral and warfarin therapy, increased by 20%,17%, 13%, 9%, 6%, and 1%, respectively. JCAHO measures for 1) VTE treatment for discharged patients with active cancer, and 2) platelet count monitoring for patients with VTE receiving UFH, decreased by 2% and 11%, respectively. The proportion of patients experiencing at least one anticoagulant related adverse drug outcome decreased by 0.5% and rates of major bleeding decreased by 1% in POG. On average, the total cost of therapy (cost of major/minor bleeding, DVT, PE and drugs costs) decreased by $105 per patient in POG.

CONCLUSION: Implementation of VTE treatment and prophylaxis guidelines improved appropriateness of anticoagulant therapy in the participating hospitals resulting in improved outcomes, reduced costs, and improved quality performance.

PDB2

HBA1C GOAL ATTAINMENT IN RELATION TO DOSE AMONG DIABETES PATIENTS USING METFORMIN

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OBJECTIVE: To study dosing frequency of metformin in relation to HbA1c goal attainment in daily practice.

METHODS: Data for this nested case-control study were obtained from the PHARMO Record Linkage System, including among others linked drug-dispensing and clinical-laboratory records of approximately three million individuals in defined areas of The Netherlands. The study cohort included new users of oral glucose-lowering drugs (OGLD) between 1999–2005, with a baseline HbA1c ≥7% and consecutive HbA1c-measurements within 18 months. Cases attained HbA1c-goal (HbA1c <7%) within 18 months. Controls did not attain HbA1c-goal. Compliance cases and controls on metformin monotherapy were included in the analyses. Dosing frequency was dichotomized into once-daily and twice-daily or more. In the multivariate analysis we considered OGLD-dose, baseline HbA1c, prescriber and number of HbA1c-measurements.

RESULTS: The study cohort included 3107 new OGLD-users. The analyses included 753 cases and 477 controls using metformin. Dosing twice-daily or more was associated with a 71% higher probability of attaining goal (OR 1.71 (95%CI 1.31–2.24)) compared to once-daily dosing, after adjustment for baseline HbA1c and prescriber. We could not distinguish between the effect of dose and dosing frequency as these were closely related. Statistical testing in the analyses stratified by dose was prohibited by small numbers.

CONCLUSION: About 40% of compliant metformin users were not at goal because of dosing problems. A strong correlation between total daily dose and dosing frequency did, however, not permit to identify one of these dosing items as most important attribute.

WITHDRAWN

PDB3

EXENATIDE UTILIZATION AND EFFECTIVENESS IN A HEALTH PLAN POPULATION

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OBJECTIVE: Numerous clinical outcomes trials have demonstrated the benefits of achieving glycemic goals in patients with type 2 diabetes (T2D). In controlled clinical trials, the incretin mimetic exenatide improved glyemic control in patients with T2D; 34% to 46% of patients achieved A1C ≤7% and mean A1C change from baseline was −0.8% to −0.9% (baseline A1C 8.2% to 8.7%). To investigate the effects of exenatide in clinical practice, this retrospective cohort study used a large, US commercial health plan claims database to describe baseline characteristics, comorbidities, concomitant therapies, and clinical effectiveness in patients initiated on exenatide.

METHODS: A total of 4936 patients were identified having a new prescription claim for exenatide between May 1, 2005 and June 30, 2006 (first claim = index date), with ≥12 months of pre- and post-index eligibility, and ≥18 years old.

RESULTS: Mean (±SD) age was 53.7 ± 10.2 years (11.7% ≥65 y; 52% female). The 12-month mean (SE) medication possession ratio (MPR = days of supply/365 days) in patients with ≥1 prescription claim was 66 ± 30%. Most patients analyzed (94%) were treated with at least one other antidiabetic medication at initiation (100 d pre-index to 15 d post-index); 25% with one drug, 35% with two drugs, and 34% with ≥3 drugs. The mean number of antidiabetic drugs (including exenatide) per patient was similar at initiation (3.08) and post-index (3.05). Clinical effectiveness was measured in all patients with an A1C ≥7.0% at baseline (≥100 d pre-index) and having both baseline and post-index (60–365 d) A1C data available (n = 201; mean baseline A1C = 8.9 ± 1.5%). In this cohort, 31% achieved A1C ≤7% in the post-index period and mean A1C change from baseline was −0.8%.

CONCLUSION: The mean change in A1C and percentage of patients achieving A1C ≤7% in this real-world analysis mirrored results of controlled clinical trials. Furthermore, glycemic improvement was achieved without a further increase in concomitant antidiabetic drugs.

PDB1

DIABETES/ENDOCRINE DISORDERS—

Clinical Outcomes Studies

EXENATIDE UTILIZATION AND EFFECTIVENESS IN A HEALTH PLAN POPULATION

Schroeder B1, Misurski D2, Wade R3, Quimbo R3, Nielsen L1, Fabumni R1, Winde M3
1Amylin Pharmaceuticals, Inc, San Diego, CA, USA, 2Eli Lilly and Company, Indianapolis, IN, USA, 3HealthCore, Inc, Wilmington, DE, USA

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