RESULTS: 3.3% of AF-patients (n = 831) and 2.5% of non-AF patients (n = 1662) had a cerebrovascular event in 1997. One-year median resource use in the AF and non-AF group was as follows: hospital days: 7.0 vs. 6.0; outpatient visits: 8.0 vs. 6.0; home health visits: 6.0 vs. 5.0; ER visits: 1.0 vs. 1.0, nursing home days: 7.5 vs. 6.0. The median annual total charges per AF patient and non-AF patient were $22,213 and $17,472, respectively. On controlling for age, gender, Charlson Comorbidity Index, type of CVD, and prior year’s hospital use, the two groups only differed significantly in number of outpatient visits. No differences in costs existed.

CONCLUSIONS: AF patient had a higher utilization of outpatient visits as compared to non-AF patients. It is possible that presence of severe underlying CVD in both groups overwhelms the differences in the costs attributable only to AF. Further examination of the pharmacy data will help reveal any differences in drug utilization and costs due to AF.

HOSPITAL TREATMENT PATTERNS AND RESOURCE UTILIZATION IN CONGESTIVE HEART FAILURE PATIENTS

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OBJECTIVES: Given the high hospitalization rate associated with congestive heart failure (CHF), the objective of this analysis is to assess hospital resource utilization of CHF patients treated with inotropic agents, diuretics or both.

METHODS: Patients hospitalized with a primary discharge CHF diagnosis between July 2000 and June 2001 were identified from a hospital-based, service-level database of 217 health care facilities. Patients managed with diuretic and/or inotropic drugs were segmented into the following treatment groups: inotropics only, diuretics only (IV, oral or both), and inotropics with diuretics (IV, oral or both). Drug treatment, hospital unit care patterns, and incurred mean total hospital and drug costs were determined for each treatment group.

RESULTS: From the patient sample (N = 58,131), 53% were treated with IV and oral diuretic therapy, 20% with IV-only diuretics, and 14% with inotropics plus IV and oral diuretics. Length of stay (LOS) ranged from 4 to 9 days, with intensive care unit (ICU) or subacute stepdown unit LOS accounting for 3–6 days and inotropic-treated cases having longer stays. Inotropic therapy was usually initiated during the first or second day of hospitalization. One-third of patients treated with inotropic drugs were transferred to the ICU during the first hospital day while one-third of diuretic treated cases received stepdown care. Patients who received inotropic therapy with oral and IV diuretics had the highest total hospital and drug costs at $12,461 and $382, respectively. In the oral diuretic-only treatment group had the lowest total costs ($4,380). Most patients were discharged home but more inotropic patients expired in-hospital (4–15%) while more diuretic cases were transferred to a skilled nursing facility (10–12%).

CONCLUSIONS: CHF cases treated with inotropic drugs had longer overall and ICU LOS, higher hospital costs and in-hospital mortality when compared to diuretic-only treated patients.

COST-EFFECTIVENESS OF THROMBOPROPHYLAXIS IN ACUTELY-ILL MEDICAL INPATIENTS

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OBJECTIVE: Clinical trials have demonstrated the safety and efficacy of prophylaxis with unfractionated heparin (UFH) and low-molecular weight heparins such as enoxaparin against venous thromboembolism in acutely-ill medical inpatients. The objective of this study was to estimate the cost-effectiveness of these alternative methods of thromboprophylaxis in this population.

METHODS: We used techniques of decision analysis and data from secondary sources to estimate the cost-effectiveness of thromboprophylaxis in acutely-ill medical inpatients. A hypothetical cohort of 10,000 patients was assumed to receive, alternatively, prophylaxis with: (1) enoxaparin 40 mg qd; (2) UFH 5,000 IU bid; (3) UFH 5,000 IU tid; or (4) no prophylaxis. For each strategy, we estimated the 30-day risks of thromboembolism (deep-vein thrombosis and/or pulmonary embolism), complications of prophylaxis and therapy (heparin-induced thrombocytopenia and bleeding), mortality, and costs of prophylaxis, diagnostic testing and treatment. Cost per death averted was assessed for each method of prophylaxis relative to no prophylaxis. A background mortality risk of 10% was assumed.

RESULTS: In a cohort of 10,000 inpatients, expected numbers of deaths over 30 days were 1,041 for enoxaparin, 1,058 for UFH bid, 1,058 for UFH tid, and 1,089 for no prophylaxis. Corresponding estimates of the expected costs of prevention, diagnosis, and management of venous thromboembolism were $3,655,800, $3,750,400, $4,300,400, and $3,363,000 (2001 US$). Relative to no prophylaxis, the cost per death averted was $6,101 for enoxaparin, $12,498 for UFH bid, and $30,240 for UFH tid. Incremental analyses indicated that prophylaxis with enoxaparin is both more effective and